Proceedings of the Workshop on Sustainable Health Care

CIDSE/Caritas Internationalis

Noordwijkerhout, The Netherlands, 25-30 September, 1995

Colofon

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Introduction

At a meeting of the AIDS Funding Network Group (AFNG) in May 1994 the need to address the issue of health services was raised. The same issue was also raised at a meeting between the President of CIDSE and the CI Secretary General. At a later meeting of the AFNG it was decided that a seminar be organised in 1995 as a joint effort between CI and CIDSE. An organising committee was set up with a brief to organise and plan the event.

The Committee met several times and the dates were fixed for the seminar from 25 - 30 September 1995. The venue for the workshop was The Congress Centre Leeuwenhorst, 2211 XT Noordwijkerhout, The Netherlands. The Internationalis Workshop was hosted by Vastenaktie/Cebemo.

Participants were invited from Africa, Asia, Europe, Latin America and North America. It was hoped that the participants and speakers would function as a "Think Tank" and begin a process of looking at models of health care to face current realities

Some 38 participants attended the workshop most of whom arrived at the Congress Centre on the evening of 24 September. On the morning of 25 September Mr. H.A.J. Kruijssen, General Director of Vastenaktie/Cebemo and the Secretary General of CIDSE, Dr. Koenraad Verhagen welcomed the participants. The keynote speech was delivered by Monsignor Priamo Tejeda and the objectives of the workshop were presented by Dr. A. Hokororo

The programme each day was flexible, - a plenary session with input on the main theme for the day, followed by case studies and group work. The methodology adopted was participatory as it was considered crucial to learn from the experience of partners involved in implementing programmes. Four working groups were organised according to languages; - 3 in English and one French group. A member from the Organising Committee facilitated each working group.

The main objective of the workshop was to examine the role of the Church and Church-related organisations in responding to emerging challenges in the field of health care and development and to explore more sustainable models for the next decade.

The process was one of open dialogue and searching between partners involved in providing the services and the supporting agencies.

The specific objectives were:

i) to analyse current political, cultural, economic, social, demographic and health-related global trends in the provision of health services.

ii) to reflect on basic theological and ethical principles and on the roles of the State and Church in providing health services.

Case studies presented by participants from Asia, Latin America and Africa facilitated the analysis of the current political, cultural, economic, social, demographic and health-related issues. Providing the participants with the realities of the constraints and experiences as well as the contextual similarities and differences these case studies ensured that discussions were both realistic and practical in terms of sustainability of Health Care.

Additional input on basic theological and ethical principles as well as on Church-State-NGO relationships both from overseas partners and from supporting agencies further assisted this initial reflection and discussion.

A copy of the papers presented is included in the report as well as the list of participants and the programme outline. Reading these it is obvious that many issues were raised. Answers however could not be easily provided. Many of the speakers highlighted the changing and deteriorating contexts in the countries with limited resources which compounds their situation in terms of sustainability of health care services. Participants did reach consensus on basic principles, challenges and model strategies which demand further reflection.

The workshop provided an opportunity for agencies to reflect together on alternative approaches to sustainable health care. In as far as it has initiated a new way of relating between partners and supporting agencies the workshop can be considered a success. Hopefully it marks the beginning of on-going reflection on the very difficult issues facing those from countries with limited resources and those endeavouring to provide support. Those of us who have had the privilege of attending hope it signals a new way of operating and relating.

Sr. Maura O'Donohue MMM

Sustained health care, its actors and aspects

Keynote Speech

Msgr. Priamo Tejeda

I Introduction

New times and new situations call for new concepts. Language must change and express the realities that arise, not as a passing fad, but as a verbal expression of new goals and commitment that must in turn create new attitudes.
This is the case of "sustained health care" or "sustained development of health" that are part of the concept of sustainable development used by the UN through the UNDP.
We need to identify the issue before we deal with it.

II Sustainable development

The UNDP's 1994 report on human development highlighted the need for a way of measuring development that had the human being as its focal point. The UNDP's 1992 report defines this new type of "sustainable" human development:
"Sustainable human development satisfies present needs without limiting the potential for satisfying the needs of future generations. It is a process in which economic, fiscal, trade, energy, agricultural and industrial policies are drawn up aiming to create a development that is economically, socially ad environmentally sustainable".

The UNDP's concern for having a vision of development focusing on the human being is not so much for the sake of humanism, but rather for the survival of the planet; humanity can survive only through this type of development.

Situations such as environmental decay, HIV/AIDS, drugs, human mobility, terrorism, etc. are seriously threatening countries all over the world. Furthermore, the extreme situation of poverty experienced by the world today is one of the major challenges to sustainable development.
The famous champagne glass of the UNDP's 1992 report tells us that 20% of the rich countries (equal to 9 countries) use 82% of the income, 70% of the energy, 60% of the food, 75% of the metals and 85% of the wood at the world's disposal. On the flip side, 20% of the poor countries receive barely 1.4% of income. The world spends $1.8 million on weapons every minute and 2,500 children die of hunger every hour.
For this reason, in 1990, the UNDP created the index of human development so as to have a guide other than just per capita income or economic indicators to measure **sustainable development.**

This new idea of development, though well defined in the report, demands a **firm political will** for its implementation. For this reason, the UNDP noted in 1994:
"Sustainable human development confronts the issues of equity, within a generation and between different generations, and allows all present and future generations to fully exploit its potential. In the latter case, sustainable human development favours persons, promotes employment and engenders harmony between nature and humanity. It gives maximum priority to poverty reduction, productive employment, social integration and regeneration of the environment".

Health plays a leading role within this concept, promoting the idea of "health in development". This idea implies that health is a fundamental component of development and not a category foreign to it.
Health must not be seen as an expense but rather as an investment in the reproduction of human capital of societies, the quality of which is vital for the production of necessary goods. In other words, we cannot speak about sustainable development without speaking of health as one of its essential elements.

It was understood as such in the International Conference of Alma Ata in 1978:
"The promotion and protection of a people's health are indispensable for its sustained economic and social development and contribute to improving the quality of life and to attaining world peace"

Clearly we cannot speak about sustainable human development without talking about health. This is why the UNDP included it as one of the 7 basic points to strive for within the framework of the 20/20 accord proposed at the World Summit on Social Development in Copenhagen.

Now we can give a definition to our theme:

Sustained health care or sustained health development is those basic services necessarily provided in the field of health in order to achieve the goal of health for all by the year 2000. This type of health is closely related to the other social sectors and is considered within the context of sustainable development as seen by the UNDP and the concept of health in development.

We suggest that sustained health care be composed of the following elements:
primary health care, with emphasis on decentralisation;
environment-friendly natural (traditional) medicine;
rational use of essential drugs;
social factors of health and availability of water;
humanisation of medicine.

Before going into a definition of each of these components, let's have a look at the world's state of health.

III The world's health situation

In developed countries, the most frequent causes of death are illnesses affecting the circulatory system and cancer, which are associated with type of diet, lifestyle and pollution.
In developing countries, the major causes of death are contagious and parasitic diseases due to malnutrition and an **unstable environment**, especially regarding supplies of drinking water.
In recent years, the pandemic of AIDS' rapid spread has impacted significantly on health expenditure and, through its socio-economic repercussions, on the development of the nations of the world.
Clearly the poor suffer the most from health insecurity both in developing and industrialised countries.

In developing countries, 85% of the urban population has access to drinking water while only 62% in rural areas.
In industrialised countries, there is a doctor every 400 inhabitants, while in developing countries there is one per 7000 inhabitants. This is misleading because most of these doctors are concentrated in the large cities.
We see that the majority of the countries in the world use costly complex technology -for diagnosis as well as treatment - to combat illnesses; this lessens the effectiveness of health services.
Illnesses such as malaria, tuberculosis and diarrhoea continue to massacre humanity despite the fact that they can be treated at a moderate cost.
We must see the health situation as within the society. According to Paganini and Cherny, the health system is an integral part of the social system and is the result of and at the same time an influence on its **historical, social, cultural, technical and political context.** For this reason, if we want to effectively transform it, we cannot limit ourselves to our own deficient subsystem (Pan-American Health Board newsletter, 1990).
In the Pan-American Health Board newsletter, Paganini and Cherny mention 4 pairs of interdependent requisites that would greatly facilitate the development of or sustained health care.

1. Equity-Quality
   The achievement of equity is a great challenge to health care systems. Equity means that each section of the population has an equal opportunity to obtain quality treatment.
   We make this rapport between these two words in the hope that everyone can access health care that is **both professional and adequate**.
   Let us take the example of infant mortality, being very high in developing countries. This principle supposes that all mothers would have the possibility to be treated by an obstetrician, rather than one section being cared for by a general practitioner and another section by the community's midwife.
   Equity-Quality means the same quality care for the same section of the population. In order for care to be optimum, it needs to include human sensitivity.

2. Democratisation-Participation
   Without the real participation of communities in confronting their own health problems, it is impossible to create responsive health care.

In order to achieve this, the nations of the world must be as creative as possible in offering spaces where the people can contribute with their ideas and to their own development. This will also permit privileged groups to understand the need for solidarity in obtaining the real participation of the whole of society.

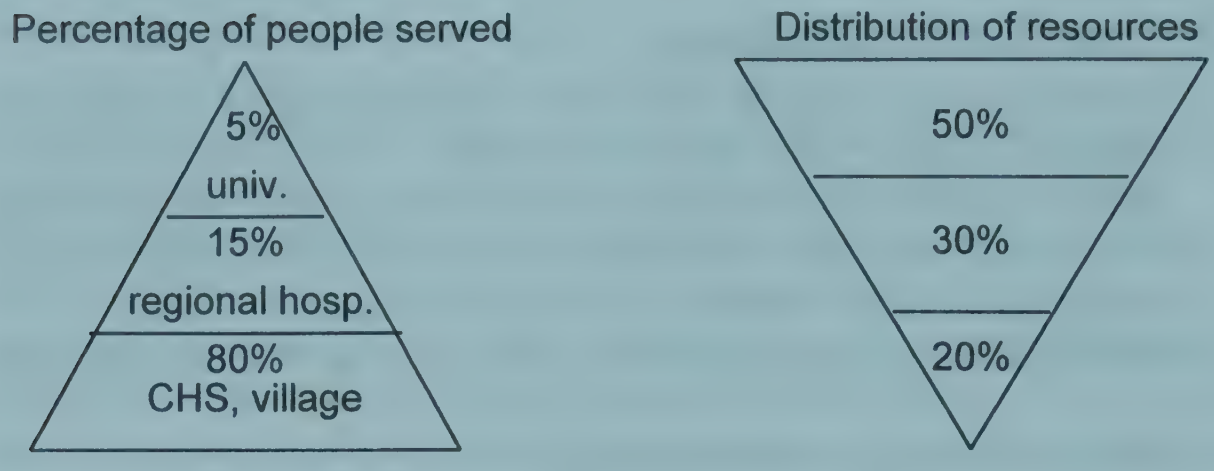
3. Development-Transformation
   Development cannot hold back the changes needed by society. The masses of society are asked for sacrifices while a minority lives in luxury. For the sake of an immediate need for social justice, our creativity must be limitless in bringing about the changes that will alleviate the grave situation experienced by poor countries.
   What we are proposing should be done in respect of our environment.

4. Efficiency-Appropriate Technology
   Efficiency means attaining quality at the lowest possible cost. Creating a ratio between efficiency and quality brings us to the concept of "appropriate technology". This expression implies the use of material possibilities and technology actually available in a given country to optimise the ratio between resources and results.
   We want to emphasise that health care must be able to pay for a part of its costs. This is important because many projects fail due of lack of financial resources; on the other hand, countries must understand that health care is not an expenditure but an investment.
   We have to see the necessary correlation among these requisites and not see them as separate entities. The application of the above four concepts demands enormous creativity.

With these four points as a framework, let us look at the five components mentioned above as necessary for the development of or sustained health care. They are:

1. primary health care, with emphasis on decentralisation;
2. environment-friendly natural (traditional) medicine;
3. rational use of essential drugs;
4. social factors of health and availability of water;
5. humanisation of medicine.

1. *Primary health care with emphasis on decentralisation*
(Health Service Area [HSA] Concept)



In the second Latin America-Caribbean Pastoral Care for Health meeting in 1994, it was said that 80% of our region's needs lay in basic, or primary health care, but that 80% of available resources go to secondary and tertiary health care and only 20% are spent on primary health care.

This information is dramatic if we consider that 17 years ago in the city of Alma Ata in the Soviet Socialist Republic of Kazakhstan the UN declared that primary health care is the strategy for achieving health for all by the year 2000, a goal we can see will be impossible. We believe that the majority of countries have an exaggerated centralisation of authority which has obstacled resources from arriving and not permitted primary health care to become a reality for the population.
Though we appreciate the efforts made in many countries, we need to **decentralise and regionalise** health services so that primary health care becomes more effective. This is why the WHO and the PHO (Pan-American Health Organisation) are promoting the "Operative Tactic" strategy for primary health care, the development and reinforcement of HSA concept, sometimes called District Health System - a key issue in achieving health for all by the year 2000.

Health Service Area concept or District Health System intends to give the leading role back to the politico-administrative unit so that these local forms of government in co-operation with the national government manage their own resources under the supervision of the country's competent institutions. This is not a model written in stone; each reality is different from the other and calls for a great deal of creativity to invent new models.

Let us look a the summary of the **definition of primary health care** as stated in Alma Ata:
"Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and **at a cost that the community and the country can afford to maintain**, at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system of which it is the central function and main focus, and of the overall social and economic development of the community."

We must adjust this concept to the reality of each country and call on the participation of the **private sector, NGOS and the Churches**, in view to creating a new participatory system where all spheres of society are represented within HSA system.
We would like to recall what are the activities that must form part of primary health care, as per the Alma Ata Declaration:

education concerning prevailing health problems and methods of preventing and controlling them;
promotion of proper nutrition;
an adequate supply of drinking water and basic sanitation;
maternal and child health care, including family planning;
immunisation against the major infectious diseases;
prevention and control of locally endemic diseases;
appropriate treatment of common illnesses and injuries.
provision of essential drugs

The "health for all by the year 2000" is very much tied to the involvement of traditional medicine, and, more specifically, to medicinal plants.
It is estimated that 80% of the world's population entrusts its health to the cures of traditional medicine.

Therefore it is inevitable that primary health care, identified as the strategy to attain "health for all by the year 2000", take traditional medicine and medicinal plants into consideration (Plantas Medicinales en el Sur Andino del Perú [medicinal plants in Peru's southern Andean region], pg. 8, Carlos Roersch).

2. *Environment-friendly, natural (traditional) medicine*

"The human being is born, grows and develops in a complex, closed and inter-related system. His home, Nature, is a living thing. He depends on it for his existence and the quality of his life and in turn, Nature depends on the human being to conserve, defend and improve through his intelligence and ability (science and technology). The break-down of or the disturbance of one of many various inter-related balances in this framework harms the others." (1987 Pastoral Letter of the Dominican Republic's Episcopal Conference).

The human being and his thirst for wealth are literally killing the environment. Some data grasp our attention: 8-10 million acres of woodland are lost every year (equal to the surface area of Austria); 65 hectares of fertile land have become desert in Africa. Three cities produce 9,600 tons of waste every year (Los Angeles, London Mexico City).

Respect for nature is urgent; for this reason, sustained health care must go back to the use of traditional medicine as it is a form that does less damage to the environment.
According to Carlos Roersch (who worked many years in the southern Andean region of Perú and at present works in a number of areas in the Dominican Republic, including my diocese, and directs the Dominican Institute of Medicine), traditional medicine is present throughout the world. Medicinal plants play an important role in traditional medicine and the WHO adopted a resolution in 1977 urging member countries to promote traditional medical systems.

What we mean by traditional medicine is the following: the sum of all knowledge and practices - whether they can be explained or not - used in the prevention, diagnosis and treatment of physical, mental and social imbalances and entrusted exclusively to practical experience and observation.

It is handed down from generation to generation orally or in written form (quoted by Carlos Roersch in his book, Plantas Medicinales en el Sur Andino del Perú, Vol. 1).

The WHO has three lines of action in its promotion of traditional medicine:

1. development of traditional techniques where the cultural aspect is of central importance;
2. integration of the traditional health system. Here, a question arises: which system should conserve its identity? The Western medical system is the used and most organised; nevertheless, traditional medicine is the widespread among the population;
3. training of professionals in both systems (traditional and "modern"). We must admit that health professionals have little respect for providers of traditional medicine (C. Roersch, idem).

3. Rational use of drugs

The pharmaceutical market is big business throughout the world and producers reap huge profits.

This economic logic has induced the world to use pharmaceuticals irrationally , and has meant that some governments invest up to 25% of their health budget in medicines. It is a market sustained by thousands of commercial name medicines composed of inappropriate combinations of drugs.

Whereas the WHO notes that essential drugs for combating the world's most important and common illnesses number no more than the 125 published by its commission of experts, in many countries we are seeing an increase in the irrational use of pharmaceuticals. The thesis of 1st Latin American Conference on Pharmaceutical Policy and Essential Drugs was that the pharmaceutical industry's excessive supply has caused the overuse of medicines. This phenomenon is characterised by:

1) too many pharmaceutical products not corresponding to the needs of the population;
2) an increase in the number of products with the same active ingredient;
3) products without the proven therapeutic effectiveness;
4) high prices for essential products;
5) scarce supply of essential medicines to the neediest.

The abuse of drugs such as antibiotics can cause epidemics because of their ability to produce bacterial resistance. It is nations' duty to direct the pharmaceutical market towards the use of essential drugs, as this lowers the cost of health care and allows the poor, and consumers in general, access to better health care.
In order to make the use of essential drugs a reality, we urgently need the education and organisation of consumers and the creation of laws that regulate the promotion of pharmaceuticals in the various countries.
The Catholic Church in Latin America has had interesting experiences in the area of traditional medicine and essential medicines through its program of Pastoral Care of Health that is present in almost all countries.

4. Social factors of health and availability of water

We must insist that in order to achieve sustainable health development we need to resolve the social problems affecting humanity. Health is not possible without access to drinking water for all, without basic sanitation, without just wage employment without social security and old age pensions and without healthy leisure activities.

Water is the most abundant substance on Earth. Unfortunately, 94% of it is salt water. Most of the remaining 6% is not easily accessible. Only 1% of the fresh water is on the surface and is readily accessible. The distribution of water in very uneven and principally located in warm and wet tropical zones; even so, we still pollute and waste it. Some 1.3 billion people (30% of the world's population) lack drinking water and 1.9 billion do not have health care services (49% of the world's population) (Towards the Summit - UNICEF - Dom. Rep. #18, 1995).

There's the story of the UN worker who asked an African woman if she educated her children on the need to wash their hands after defecating. The mother responded angrily, "I have to carry the water on my back 11 kilometres every day. If I caught anyone wasting water to wash their hands, I would kill them". (*Manos Unidas* bulletin, #7).

This shows the dramatic situation regarding the availability of world's water.

The Director General of the WHO, Halfdan Mobler, rightly suggested that "the number of water faucets per thousand people is a better indicator of the health situation that the number of hospital beds". Water is, without a doubt, the most important social factor affecting health.

We are presently going from a widely accepted biomedical and Cartesian concept of health to a socio-ecological paradigm that once again considers health as the result of balances between persons and environmental factors such as wind, temperature, water, sun and food (2nd Latin American Meeting on the Pastoral Care of Health, 1994). To these factors, we would add a better distribution of social wealth.

5. Humanisation of medicine

The humanisation of medicine is vital for us Catholics. At the 2nd International Conference on the Humanisation of Medicine in 1987 in the Vatican, the following ideas came forth:
"Any refusal or exploitation of the human person from conception to the oldest age goes against the nature of medicine itself.
Medicine is service to human life and is at the service of the human being, the human being as a whole and every human being.
This issue goes to the very heart of the right/duty to defend and promote life and the dignity thereof.
Among other things, humanisation means openness to anything that can aid in understanding the human being; one of its functions is to ensure that **health policy throughout the world has the well-being of the human person as its sole objective**."

The humanisation of medicine corresponds to a duty of justice. If there is a single element without which it is impossible to speak of development, it is this one.

We are living in a world that tends to dehumanise. The sector of health is no exception. We want to make our voice heard and inject the spirit of the Good Samaritan into the practice of health in order to give all of humanity the best of ourselves.

The Pope's teachings have inspired us on numerous occasions towards a human practice of medicine. For us Christians, solidarity and justice for the poor are a theological point of encounter with the Lord.

The pandemic of HIV/AIDS has forced us to re-evaluate this concept of humanisation, as there are numerous reports of attitudes of refusal and prejudice among health workers.

IV Epilogue

A strong political will is necessary to implement these ideas. Many of these concepts call for foundation work - the foundations of a building are not seen but they are essential.
These ideas often stay in black and white and on an official level and do not reach the other levels of society, the NGOS, grassroots groups, Churches, etc.
In some countries, health spending within the national budget is managed according to whim and does not follow established health standards or plans signed as part of international accords.

- Health providers (doctors, nurses, health workers) with an integral concept of health -without the distortions of schools and training centres - are needed. We need to create a new generation.
- We need more responsive and aggressive primary health care with the participation of the local community, ecological criteria in the practice of medicine such as environmental recovery, traditional medicine, essential medicine, etc.
- We need to give attention to the social factors that affect health.
- We urgently need to deal with he problem of water in our communities.
- We have to insist in more co-ordinated and wider-ranging action against the pandemic of HIV/AIDS and for the pastoral of the Good Samaritan (as we call it my country), as a witness of faith, as real Caritas shedding rays of hope.

The question remains: what is sustainable development or sustainable health care for?
To my opinion it is for a fuller, more human life of better quality and in harmony with the Creation.

I will conclude with the words of John Paul II from his encyclical Evangelium Vitae:

"The commitment to serve life is an obligation for all of us and for each individual.
All of us must feel the duty to proclaim the Gospel of life, to celebrate it in the liturgy and in all of our existence and serve it through the various initiatives and structures of support and promotion."

The role of the Church in delivery of sustainable health care: reflection on basic theology and ethical principles

Peter J. Henriot, S.J.

Health care has long been associated with the mission of the church to evangelise, to bring the Good News to all nations. In Mark's account of the missioning of the first disciples after the Resurrection, Jesus promises that believers would "place their hands on sick people, who will get well." (Mark 16:18) This ministry of healing is a continuation of Jesus' healing activity. Throughout the Gospels, we have examples of the cure of the sick as a integral part of the preaching of the coming of the Kingdom of God (e.g., Luke 10:9). In its missionary activity world-wide, the church has always had a role in the delivery of health care.

Will that delivery of health care be sustainable? This question that we struggle with during this workshop takes on a particularly urgent character when we reflect on the **reality** confronting the countries that serve as the focus of our attention, the "countries with limited resources. " (Is this the *politically-correct* language for the "poor countries"?

My own reflections come from the stance neither of a theologian nor a health-care professional. My training is in the political economy of development and my immediate experience is in a very poor African country. Therefore in preparing the topic assigned to me, I was particularly touched by the message of the World Health Organisation's publication earlier this year, *The World Health Report 1995: Bridging the Gaps.* I am sure that many of you also have read this and have equally been touched by the power of its opening paragraphs:

The World's most ruthless killer and the greatest cause of suffering on earth is extreme poverty.
Poverty is the main reason why babies are not vaccinated, clean water and sanitation not provided, and curative drugs and other treatments are unavailable and why mothers die in childbirth.

Poverty is the main cause of reduced life expectancy, of handicap and disability, and of starvation. Poverty is a major contributor to mental illness, stress, suicide, family disintegration and substance abuse.
Poverty wields its destructive influence at every stage of human life from the moment of conception to the grave. It conspires with the most deadly and painful diseases to bring a wretched existence to all who suffer from it. During the second half of the 1980s, the number of people in the world living in extreme poverty increased, and was estimated at over 11 billion in 1990 - more than one-fifth of humanity[1].

Our discussions here go on in the face of this recognition that poverty is the number one health problem in today's world. What we say about the church's role in the delivery of sustainable health care must of course address that sad fact. My contribution in this presentation is to provide some contextual theology and macro-ethical principles for us to reflect on as we look at this topic.

A changing context

Today the delivery of health care by church-related institutions and organisations continues to go on around the world as it has for many centuries. But within many of the countries with limited resources, there is a new context for the church's role. This new context is marked by two significant movements, two important transitions. These are the movements toward (1) *political democratisation* and (2) *economic liberalisation*[2]. The first provides a new context for church-state relations, and the second a new context for meeting the economics of health care. Because this topic is so broad, let me narrow it to the continent of my own experience, Africa, and be very specific with examples from the country of my own mission, Zambia.

Political democratisation is the transition from authoritarian regimes to forms of government that allow greater popular participation under a constitutional rule of law that respects basic human rights. The 1960's in Africa was the period of "First Independence," when freedom from colonial rule was achieved and national identity secured. Hopes were high, as majority rule governments took control and parliaments with multi-party organisation were put in place.

But the experience of full freedom and dignity was short-lived in many if not most of the new African states. For a variety of reasons, internal and external, the hopes of the First Independence gave way to the rise of one-person and one-party totalitarian rule, and, in many instances, the oppression of military dictatorship. By the end of the 1980's, out of the 44 sub-Saharan African states, some 38 were governed by authoritarian regimes.

Then a new experience of "Second Independence" began in the 1990's throughout Africa. Again for a variety of internal and external reasons, there has occurred a move toward political democracy, the rise of or return to a system of multi-party competition, the respect for a free press, and the hope of protection and promotion of basic human rights. In Zambia, for example, we ended a period of 27 years of one-person, one-party rule with a peaceful transition in 1991 to multi-party democracy. Other African countries have experienced similar transitions. South Africa, of course, is the most dramatic instance of transition to democratic majority rule and offers the greatest hope even amidst extremely difficult circumstances.

But the political democratisation movement is still too young to make evaluations of its success or predictions of its sustainability. In many parts of Africa there have been setbacks -- most notably in Nigeria with the retention in power of a cruel military dictatorship. But what is important for our discussions here is that the movement for political democratisation provides a new context for the church's mission of health care. Another paper of this Workshop will specifically address church and state relations. Here it is sufficient to point to two questions that arise: (1) is a democratic context more conducive to the orientation of health care under church sponsorship? and (2) does sustainable health care itself require today a more democratic style?

Economic liberalisation is the transition from a centrally-planned, state-controlled economy (socialism) to a free-market, privatised economy (capitalism). For a variety of reasons, internal and external, African economies declined in the period after Independence. Deteriorating terms of trade, increasing debt burdens, mistakes and misplaced priorities meant a fall in production and a decline in standards of living. Basic services and infrastructures deteriorated.

Social indicators of health and education that had risen after Independence took a turn downward. By the end of the 1980's, of the poorest forty nations in the world, 27 were in sub-Saharan Africa.

In an effort to turn around the economic decline of Africa and address the serious problems of widespread poverty! the international donors began pressuring governments to change significantly the direction of their economies. The model of change adopted was that formulated by Northern economists associated with the International Monetary Fund and the World Bank. The "Structural Adjustment Programme" (SAP) is an effort to bring short-term *stabilisation* (e.g., through devaluation, budget constraints, credit restrictions. etc.) and long-term *restructuring* (e.g. through removal of price controls, privatisation, trade liberalisation etc.). Faithful adherence to this economic liberalisation is now a condition for any further aid and assistance[3].

The experience of a country like Zambia is illustrative of the problems created by SAP. First, there is widespread suffering of the people. The elements of SAP such as the withdrawal of subsidies, imposition of fees in health and education, and retrenchment of workers impose especially hash burdens on those who are already suffering. This is a point strongly made by the Zambian Bishops in their 1993 Pastoral Letter, *Hear the Cry of the Poor.* Second, there is serious questioning of the long-term development consequences of SAP since it does not address questions such as employment generation, agricultural production to feed the nation, the informal sector, regional co-operation. and the environment.

This is not the place to go into detailed analysis of the economic liberalisation movement. Other workshop papers will take up questions of resources, financial aspects, etc. But it is possible to point to two questions arising in this new context for the church's health care mission: (1) What is the impact of increased poverty and suffering of the people on demands made on the church's health mission? and (2) Will governments make increased efforts to put health care back into private hands of groups like the church?

The context for the church's health care mission is of course affected by other important events on the continent of Africa, all deserving much more analysis than is possible here. These events include:

- The rise in internal conflicts such as that experienced in Somalia, Liberia. Rwanda and Burundi, and the danger of regionalisation of these conflicts.

- Increased numbers of refugees and internally displaced people, caused by these conflicts and also by natural disasters such as droughts and pestilence.

- The HIV/AIDS pandemic with consequences not only for health care but for economic development and political stability.

Theological reflection

Theological reflection is necessarily *contextual*. For this reason, this paper has begun with an analysis of the changing context. To discuss the role of the church in the delivery of sustainable health care it can help to provide a theological model that addresses the challenge posed by the two movements of political democratisation and economic liberalisation. Such a model will by no means provide specific answers for the difficult practical questions of day-to-day health care but can provide a framework for evaluation of what is currently going on and for stimulation for our thinking and planning about new directions for the future.

I want to suggest as a theological model the three-fold action of the Good *Samaritan* that we find in the well-known Lucan parable (Luke 10:30-37). The Samaritan's response to the health care needs of the person beaten by robbers and left for dead along the Jerusalem-Jericho road included these elements:

> *compassionate awareness:* not ignoring the needs despite pressures to do so
> *effective immediate response:* providing personal care even at great expense
> *long-term structural response:* providing institutionalised care in co-operation with others

To begin with, the church's sustainable health care must be *compassionate.*

One writer describes compassion as "that divine quality which, when present in human beings, enables them to share deeply in the sufferings and needs of others and enables them to move from one world to the other; from the world of helper to the one needing help; from the world of the innocent to that of sinner"[4] Jesus in his ministry is certainly the model of compassion, as again and again we are told in the Gospels that he is moved with compassion to take some healing, comforting, uplifting action (e.g., raising the widows son, Luke 7:13; feeding the 5000, Mark 8:2; teaching the crowds, Mark 6:34); healing the sick, Matthew 14:14).

Coming along the road to Jericho after the priest and Levite, the Samaritan sees what they also had seen: a man lying badly injured in the road. But the Samaritan sees with the eyes of compassion and enters into the suffering man's world. His awareness is not blocked by the pressures of going off for other important business, of fearing what involvement might bring, of revulsion toward such pain and anguish. He does not ignore the needs of the man precisely because he has been moved by compassion; his is a compassionate awareness, much deeper and much more compelling than the superficial and selfish awareness of priest and Levite.

In today's context of economic reductionism, there is little place in government and business policy circles for compassion. The neo-liberal economics that guides structural adjustment programmes creates pressures to ignore and marginalise the poor and the suffering. Compassionate awareness is blocked by systemic emphases on budgetary constrains competition efficiencies, bottom-line exigencies, etc. Furthermore. the sheer magnitude of human suffering in much of the world has given rise to the frightening phenomenon described as "compassion fatigue": people are simply exhausted, worn-out and wearied by stories of and contact with those who are suffering. "Don't tell us any more! We've done our part" (Who knows, possibly the priest and the Levite had just come from tending to the needs of many others who had been beaten up on the road to Jericho?!)

This theological model tells us, therefore, that sustainable health care in today's context must be motivated by a compassionate awareness that may be pressured and may be wearied but is never blinded.

The second thing to note in the Good Samaritan model is the *immediate personal response.*

The Samaritan takes time to become personally involved, providing what help he can at the moment: "he poured oil and wine on his wounds and bandaged them; then he put the man on his own animal and took him to an inn, where he took care of him." (Luke 10:34) Throughout the Gospels, we have stories of how Jesus reached out and touched someone in need, a sign of his personal involvement (e.g., curing a leper, Luke 5:13; straightening a crippled women, Luke 12:13; healing a deaf-mute, Mark 7:33; comforting Peter's mother-in-law, Matthew 8:15: feeding his own disciples, John 21 :13). His was not a distant. aloof, detached ministry. He became personally involved and shared whatever he could. most especially his loving presence and personal touch.

What does this personal involvement shown in the Good Samaritan model say to our efforts for sustainable health care in today's context? As I will explain in greater detail later in this paper there is a serious tension in health care in the industrialised world between two competing models of health care: health care *ministry* and health care *industry.* In the former model, there is more personal, hands-on emphasis; in the latter, a technical. specialised approach means greater de-personalisation. But as you know so very well, personal involvement, the personal touch, is a medicine that no amount of technological sophistication can replace.

Our theological model thus points to the fact that sustainable health care must emphasise personal involvement of health-care givers.

Finally, we need to take note of the *long-term structural response* present in the Good Samaritan model. Not only was the Samaritan compassionately aware and immediately involved; he was also committed to further assistance through arrangements that involved planning, financing, and co-operative efforts. "The next day he took out two silver coins and gave them to the innkeeper. 'Take care of him,' he told the innkeeper, 'and when I come back this way, I will pay you whatever else you spend on him.'" (Luke 10:35) The Samaritan took steps to institutionalise the care given so that it would be effective. As important as his own immediate and personal care was for the injured person, it was not enough.
This "institutionalisation" of loving care has been a mark of church-related health care over the years, in the best sense of the word. Hospitals, clinics, hospices, homes, etc., are all ways of assuring that the loving care can go on.

Indeed, the establishment of these institutions by the church was a significant step toward "sustainability" of health care before that phrase ever became popular. In the tight economic situations of today in countries with limited resources, commitments to institutions may be more difficult but also more necessary. The control over these institutions -- not simply in financial terms but also. and more importantly, in terms of values -- is also a serious challenge in the new political environment.

Thus, sustainable health care in today's context must, according to our theological model of the Good Samaritan, find ways of effective institutionalisation of the compassionate and personal response of the church.

Ethical principles

In looking at ethical principles that would guide the church in the delivery of sustainable health care, I want to make an initial distinction between the *macro*-ethical and the *micro*- ethical .

> *Macro-ethical* principles guide societal and institutional response and refer to topics in social policy areas such as access of the poor to facilities, priorities for the future, etc.
>
> *Micro-ethical* principles guide individual response and refer to topics in personal choice areas such as contraception, maintenance of life-support systems, etc.

Because my own training and experience is in the field of the political economy of development, my focus here will necessarily be on the macro-ethical principles. Someone with more specialised medical ethic background would have to address the micro-ethical principles. But I will say this. From my involvement in consultancy with church-related health care systems in the United States in the 1 980's, my impression is that considerably more attention has been spent on the micro-ethical issues that on the macro-ethical issues. That has meant in practice that some very significant points regarding institutional practices have not been subjected to as critical ethical evaluation process as have been individual practices of medical personnel.

An obvious point is that the ethical demand of concern for the poor - the implementation of the church's mandatory "option of the poor" - has significant consequences that should affect institutional decisions and policies[5].

For provoke our discussion here this morning, to stimulate questions in our discussion groups today, and to focus our potential resolutions in the days ahead, let me suggest a set of four macro-ethical principles that should guide the role of the church in the delivery of sustainable health care. These principles are related and all can be rooted in the theological model of the Good Samaritan that I have presented. As you hear the principles, I ask you to apply them to your own specific experiences and test their validity and relevancy.

Sustainable health care in today's context should be primarily

1. Ministerial (not industrial)

"Sustainable health care should follow a ministerial model and not an industrial model."

This first and indeed foundational principle states very simply that providing health care is a form of service in and for the community before it is a form of economic activity, a commodity exchanged for profit. Care is to be provided for whoever needs it. Who pays for that care is an important consideration, but it definitely is a secondary consideration. This at least has been the traditional ethic guiding health care over the years.

Now this principle may be simple to state, but it is increasingly difficult to implement. Of late, particularly in the rich countries, health care has followed more of an *industrial* model than a *ministerial mode*[6]. This is understandable given the pressures arising when health care assumes the economic proportion it does. For example, in the United States of America health care currently accounts for more than 14% of the annual GNP. The fastest-growing sector of health care activity is the for-profit sector.

The *ministerial* model of health care emphasises:

- the service of persons with respect for equal dignity of all
- a holistic approach relating to the whole person in the whole community
- a focus on the spiritual dimension of the person
- a preference for the poor, the so-called "option for the poor"

The *industrial* model of health care emphasises:

- the pursuit of profit for a return on investment
- specialisation for efficiency with attention to individual parts
- technological effectiveness
- competition in order to survive economically

Although these models can be complementary -- one must survive in order to serve! - they also can be conflicting in the values, directions, standards and ethos of an institution. For example, the option for the poor may be pressured to give way in the face of stiff competition and budgetary constraints. Sustainable health care in a church-related institution in today's political and economic context must be guided by this macro-ethical principle of ministerial service if it is to maintain the religious character, the link to Jesus' ministry of evangelisation, that was mark of its founding.

2. *Holistic (not isolationist)*

"Sustainable health care treats the whole person in the whole community, not isolating personal parts from the rest of the body or individuals from the rest of the community."

This ethical principle recognises that a human person is not a unique organism with isolated problems, but a whole. Not just a whole individual person either, but a part of that whole that is the web of relationships to the wider community, to the person's family, to their work, to their social situation.

Sustainable health care is guided by this principle when it avoids a hyper-specialised approach to taking care of a sick person or to preventing illness.

I am more than my inflamed appendix, more than my malaria-caused fever. There is a spiritual dimension to my existence, in the sense of my beliefs, my hopes, my loves. This dimension too must be taken into account when I am seeking health care. For example, other professionals in society must be recognised besides simply the physician or the nurse. Religious personnel are not simply for offering "spiritual consolation" but have a significant role in the preventive and curative processes.

Moreover, I am not alone, a *lone* individual. There is a *societal* dimension to my existence. a dimension that cannot be ignored in diagnosing needs and in prescribing remedies. Families, support groups, work places, all come into consideration in an holistic approach. And the cultural aspects of my existence are likewise seen as important. This is especially true where explicit cultural emphases are significant factors in holding a society together and in giving it its identity.

One consequence for sustainable health care guided by this holistic principle: the role of the traditional healer and of traditional medicine assumes a much more important role. This is certainly true in Africa. Recently I was speaking with some African friends who told me of the significance of advice from traditional healers and of the use of herbs, special diets, etc., that followed traditional patterns. They were not speaking of consulting the *ng'anga* (witch doctor) for medicines to seek revenge or enhance domination. Rather, they sought to be in touch with the wisdom of a community that knew health remedies before the chemistry, technology and "scientific rationalism" of Western medicine came to control so much of health care activities. There is greater interest today in this traditional wisdom. It is certainly in line with the holistic ethical principle we have been speaking of here.

3. Structural (not symptomatic)

"Sustainable health care should take account of the structural causes of sicknesses and not deal only with the symptoms."

It is certainly clear from our earlier discussion of the changing political and economic context that sustainable health care is profoundly affected by what is occurring today in countries with limited resources such as African countries. The structures of political participation and of economic distribution touch the life and the livelihood of every individual. Institutions and services of health care are themselves involved in the transitions taking place around them.

It is for this reason that church-related sustainable health care must be guided by an ethical principle that recognises the deeper causes of sickness in society, especially sicknesses that affect the poor. Dr. Paul Farmer, a physician and anthropologist at Harvard Medical School who has worked in rural Haiti, has argued that health care is ineffective in poor societies unless it addresses the deeper, poverty-related forces that are the root causes of many of the serious diseases on the increase, such as tuberculosis[7]. If TB, for example, is viewed as an exclusively biological phenomenon, then available resources will be devoted to pharmaceutical and immunological research. If the problem is viewed primarily as one of patient compliance (e.g., whether or not medicine is taken, diet is followed, etc.), then plans will be made to change the patients behaviour. But if a more serious structural analysis is done, and the poverty-related forces are identified (e.g., overcrowding, hunger, lack of education, inability to pay for drugs, etc.), then effective sustainable health care must also necessarily address these forces.

What strikes me about Dr. Farmer's analysis is that it is remarkably substantiated by the *World Health Report 1995* that I referred to at the opening of my remarks. According to WHO, "The world's biggest killer and the greatest cause of ill-health and suffering across the globe is ... extreme poverty." And this poverty affects people in a variety of ways. Let me give an example that I know of from personal experience in Zambia. The UNICEF efforts to promote universal immunisation have been very successful in our country - a rate of 88% for tuberculosis, for instance. But this rate has been falling off in the past year or two, as very poor parents have stayed away from clinics that now are charging user fees (because of SAP). Although the immunisations are free, they are associated in people's minds with clinics that charge fees for other services - and are avoided.

Health care cannot. of course, solve problems of poverty. The point I am making, that sustainable health care must be guided by a macro-ethical principle that recognises that sicknesses and ill health are in many instances caused by the deeper societal structures of poverty, inequity and injustice. It does not help to address only the symptoms; the structures must also be addressed.

4. Liberative (not dependency-building)

"Sustainable health care should be liberating to all those involved, health-care givers as well as receivers, and not build dependencies."

In countries with limited resources, one of the most serious challenges in the development process today is to avoid building bonds of dependency. A major critique offered in recent decades of "developmentalism" -- the political-economic ideology espoused by many Northern countries and donor institutions -- has been that it ignored the structural dependency existing in North-South relationships. Structures of trade, aid, investments, and monetary arrangements have all maintained the dominant influence of the rich countries.

These dependency relationships can of course, also go on within and between organisations and between individuals. It is thus a challenge to design and implement relationships that are liberative and not dependency-building. This is true in the efforts of sustainable health care. On the level of individual interactions, it is important that the style of exchange between the health-care giver and receiver be such that people are empowered to build on their own ideas. to make new discoveries for themselves. The people must become actively responsible for their own and the community's health. To use the expression of Paulo Freire, people become *subjects* of their own development, not *objects* of someone else's efforts to develop them.

In Zambia, we make use of a popular development education approach called "Training for Transformation" that is based on Freirean methodology[8]. (It is also used in several other countries in eastern, southern and western Africa.) I myself have participated in programmes with health care workers in which the emphasis has been in the liberative direction.

Local communities build their own clinics; local health workers involve people in education, nutrition, sanitation, and environmental programmes. The well-known handbook for village health care, *Where There Is No Doctor, is* another excellent example of promotion of a liberative health care approach[9].

There is also the sensitive issue of the dependency on outside funding of church related health care efforts in countries of limited resources. This is surely an issue of importance for the members of this audience and for the CIDSE/Caritas Internationalis sponsors. The dilemma is that without some outside assistance, much health care would be curtailed. Yet the question arises: does outside assistance build dependencies and also absolve local governments, groups and individuals from their political and personal responsibilities? (This is not an academic question for me in Zambia, since I personally arrange for donations of much-needed medicines to be shipped from the United States to our mission hospitals that experience the constraints of severe national poverty.) The African Synod message of last year made the point in general terms in a paragraph significantly entitled, "Examination of Conscience of the Churches in Africa," when it stated: "Our dignity demands that we do everything to bring about our financial self-reliance"[10].

Conclusion

What "sustainable health care" demands in the situation of countries with limited resources will become more clear over the remaining days of this workshop. What I have attempted to do in this presentation is to provide an analysis of the context of political and economic transition; to offer a model of contextual theology based upon the compassion, personal involvement and institutional commitment shown by the Good Samaritan; and to suggest a set of macro-ethical guiding principles that emphasise a ministerial, holistic, structural and liberative approach.

I close where I opened by repeating the message of the World Health Organisation: "The world's most ruthless killer and the greatest cause of suffering on earth is ... extreme poverty."

Can we of the church find a role in the delivery of sustainable health care in such a world? Faithful to following the way of Jesus who said, "I have come that they may have life and have that life more abundantly" (John 10:10), we must seek our role humbly, wisely, courageously.

Notes

1 World Health Organisation, *The World Health Report 1995: Bridging the Gaps* (Geneva World Health Organisation 1995) p.1.

2 For a more complete treatment of these topics, see Peter J. Henriot, SJ..., *"The Social Context of the AMECEA Countries on the Eve of the African Synod," AFER* (African Ecclesial Review) Vol. 34, No. 6, December 1992, pp. 340-363.

3. For further explanation of SAP, see Peter J. Henriot, SJ, *"Effect of Structural Adjustment Programmes on African Families,* in *African Christian Studies* (Journal of the Catholic University of Eastern Africa), 1995.

4. From a privately circulated paper by Howard Gray, SJ, *"Moving Ahead".*

5. See Peter J. Henriot, SJ, *"Service of the Poor: The Foundation of Judeo-Christian Response,"* in James E. Hug, SJ, ed., *Dimensions of the Healing Ministry* (St. Louis: Catholic Health Association, 1989), pp. 66-85.

6. See Peter J. Henriot, SJ *"Catholic Healthcare: Competing and Complementary Models",* in Hug, Op. cit., pp. 19-19-35.

7. Paul Farmer, *"Medicine and Social Justice", America,* July 15 1995, pp. 13-17.

8. Anne Hope and Sally Timmel, *Training for Transformation: A handbook for Community workers,* 3 vols (Harare, Zimbabwe: Mambo Press, 1984).

9. David Werner Where *There is No Doctor: A Village Health Care Handbook for Africa* (London Macmillan Publishers, 1987).

10. *"Message of the Synod."* #44, in *The African Synod* (Nairobi: Paulines Publications Africa, 1994) p. 26.

The role of NGO's, church and state in Health care delivery

Prof. Dr. Lieselotte de Barragán, MPH

When mankind developed into communities, communities have taken care of their vulnerable members, those affected by wounds, sickness, young children, the elderly and the disadvantaged. Some members of the community learned, practised and transmitted special skills to treat physical and mental illness, to mediate between man and spiritual power, and to read future happenings from natural events and supernatural manifestation. Solidarity was personal, concrete and immediate.

When communities developed into societies and states with numerous and increasingly anonymous members, satisfaction of needs became a function of wealth and causes for vulnerability enlarged as a function of poverty. Poverty also generated new forms of social threat, as the spreading of plagues and violence. Taking care of vulnerable groups thus broke the frame of concrete, personal help and required increasingly complex structures. Professional helpers, such as healers, teachers, scriveners were kept and paid by the State, enjoying much consideration and holding a high social status, as in ancient Egypt, China or the Inca States. Under the feudal system, institutions rose to dispense goods and care according to needs and ails in the name of charity, organised by the Church and well known personalities with philanthropic intentions, mediating between the helping and the helped. Growing population, concentrating in cities due to industrial development, required increasing social organisation for the production and distribution of goods and services, which led to the ideological and political organisation of economical growth and social welfare through the State. Solidarity became abstract, individuals granting the funding of a social system of rights and duties through taxation and social security contributions.

These increasingly complex forms of solidarity did nor develop simultaneously in all societies, nor within any given society. They can all be found coexisting. Personal and concrete solidarity still exists where people live together in small, isolated places, and in clans and families.

The Church still helps in the name of charity, and philanthropic donors distribute funds, goods and services through foundations and non governmental organisations where the State does not - or not sufficiently - reach vulnerable groups, be it because of financial, technical or organisational deficiencies, and/or because of political or ideological reasons.

Different ideological approaches have given birth a number of theories on vulnerability and poverty, their causes and consequences, how to deal with social and economical growth, how to ensure sustainable development, it s ethnical, cultural, and religious implications. Social changes and technological development open a wide range of opportunities for personal growth which should be available to everybody. Justice, ethics, equity, participation, social acceptability, scientific soundness, feasibility, responsibility, accountability and many other key concepts have been analysed and discussed. The need to keep a useful member of the tribe alive and capable has developed into the right of every human being. whatever her/his condition, to be supported in all physical, psychological, spiritual and environmental needs. That this right can not be exercised without considering the same right for every living creature for the earth and the water and the air, has been recognised rather recently.

Many conferences on these issues have taken place over the last fifty years. Countries have gathered in the United Nations to work on common issues and solve more and more threatening problems for mankind and the Earth. Immense resources have been spent, tons of goods have been shipped all over the world. Countless projects have been started, carried through, succeeded or failed. Science and technological development have lifted man up to space, communication and information have shrunken any possible distance into seconds and fractions of a second. But in spite of all these efforts, four out of every five persons live in poverty, with the attached vulnerabilities, lacking basic goods and services, unable to compete with others to reach opportunities not only related to survival, but also for physical, cultural and psychological growth, actually or potentially violent against themselves or society or both.

There should be more efforts. There should be more resources. There should be more commitment. Instead, resources become less sufficient, solidarity more difficult, results often discouraging, social pressure increasing with spiralling population density, personal isolation and frustration.

A human being is capable of developing his physical, mental and spiritual potential only when his basic needs are met. He has to have access to education and health. Otherwise, he will not be a productive member of society. If society needs productive members, members of society need basic goods and services. How can the costs of basic goods and needs be covered? There is no problem when a society has enough producing members who can contribute for those members who Ire not yet or not any more productive. These societies have strong collective constitutions and state organisations to grant social welfare. The challenge arises when global production o~ society s members does not cover the costs of basic needs, even more so because a less productive population is condemned to stay poor and less developed, since development is very strongly related to productivity, in turn linked to health and education.

Even if the State exists, collective constitution and organisation are weak and insufficient, leaving large parts of territory and population uncovered, specially with social services. A first strategy for survival of these populations is to expand the productive life span: child labor and labor of the elderly. But this strategy will not succeed in providing basic services. It will keep the young away from adequate schooling and health care, preventing the development of their full potentials and perpetuating the circle of poverty. A second strategy lies in the organisation of the community to provide for basic services. This can be achieved by voluntary work as a form of payment for infrastructure, and actual payment with money or goods for a given service. The result is as poor as the investment: children continue to work, education hardly goes further than minimal knowledge of spelling and counting, labor extends to the whole life span, life expectancy is low. Pregnant women labor until delivery and immediately after the child is born. If this situation is to change, intervention of other more structured and developed social organisations in addition to the State is needed. The questions are: what kind of organisations are needed, and what should be the role of these organisations?

The Church has provided charitable services for the poor from the time of its existence. Later on investigation and scientific work in all fields of sciences have strengthened, increased and enriched the institutional structure of the Church and her fields of intervention, including political influence.

Working with basic services for the poor, three main roles of the Church can be identified at present: financial subsidies, organisational structuring and confessional mission. The help of private benefactors also changed from direct gifts to the poor to structured and aim oriented work, channelled through foundations or non profit organisations, known today as non governmental organisations. The role of these institutions is to provide financial subvention, organisational structuring and social promotion without discrimination

The work of the Church and of NGOs has largely substituted the work of the State. In some cases connection with the State has simply been considered unnecessary and probably a nuisance, in other cases work was coordinated, in other cases the State was confronted, depending on the political orientation of a given government. Until recently, the substitutive work of the Church and NGOs was seldom, if ever, questioned, countries and communities feeling somehow thankful for the help given to the poor.

Today, increasing population, increasing demands, increasing complexity of developmental issues and also increasing conscience of unmet human rights, together with increasing needs considered as basic, face growing insufficiency of resources for social services and the challenge to build a solid system of social welfare where taxation and social security contributions are almost impossible. Compulsory voluntary work of the poor, sometimes hidden under the denomination community participation, is not acceptable any longer, since participation means analysing a given situation, setting priorities and determining how to reach a given goal.

The United Nations have set justifications, reasons and goals to be reached by the end of the century in Environment, Population, Health, Education, Water, Women's and Children's Rights, with commitments signed by most countries of the world. The State, the Church, NGOs, other civil institutions and popular organisations and communities have to work together to reach these goals. This is a very different approach from the concept of either the State, or the Church, or a NGO working for a poor community of poor people, giving this community what the State, the Church or the NGO consider the community needs, with the additional constraint of what the funding developed countries, Churches or philanthropic institutions have set as their own policies and priorities.

Most communities are organised around a Municipality, whose authorities are elected or nominated by respected people. Other communities have traditional authorities, appointed by traditional usage. In suburban communities district authorities are either elected or delegated by the Mayor or City Councils. Usually. these authorities submit the community's needs to the government with little if any hope of success. Since they have no resources. [hey may contact or be contacted by religious or civil institutions who decide to carry out projects or programs of development or social services, perhaps co-ordinating voluntary work to build health posts, schools or water supply systems, with little affective involvement of the community, which does not consider the project as its own. In some cases the project can be considered as owed to them because of their poverty.

This is a perverse ideological form of turning poverty into a right, with no responsibilities, paradoxically caused by well meant "conscientisational" projects. The result usually is little use of facilities, continuing child labor without attending school or easy drop out, few and too late consultation at health services, while traditional healers and midwives stay aside and confront the western medical model, partly because of cultural reasons, partly because it threatens their own survival. Funding becomes even more difficult when cost recovery even by small payments is rejected out of the feeling that institutions use their poverty to raise funds for their own sake.

Since foreign projects' professionals are paid several times more than national doctors or nurses and are given cars and housing, this impression grows also among local professionals. When the time assigned to the project elapses, local governments usually have taken no provisions to take over either the payment of human resources nor the maintenance of physical structures. In these cases either the leaving institution looks for another institution to take over, or the whole project succurnbs to failure.

There is not much hope for changes unless the cornmunity is empowered to feel that health and other basic services belong to them because their felt need is taken into account, local situations are discovered, causes and consequences analysed, possible and feasible actions considered, planned. organised. carried out. controlled, evaluated and accounted for. so that the cornmunity will support the services. This process can be started by the Church or an NGO.

But it will never be more than a start if the State does not give local governments, like Municipalities or other territorial organisations - as is the case for indigenous groups - power and means to decide and to carry out their own decisions.
This means a fair per capita distribution of tax income among total population, allowing small communities to grasp the concept of ''human capital'': the State transfers to Municipalities and/or local indigenous authorities a certain amount of money, according to certified local population, with clear responsibilities and rules and methods of accountability. As a result, all communities have funds to use for local needs. Small communities will have small funds, and will still need co-ordinated institutional help from the State, the Church or NGOs. Cost recovery is then made possible even in case of indigent patients, where municipal resources cover treatment and/or referral to more complex health services through social special solidarity funds, thus making health care sustainable, which means it can be funded, and sustained, which means it will be supported by the community.

On April 20 1994, the Congress of Bolivia approved the Law of Popular Participation. According to this Law, 20 % of the national tax income is distributed among Municipalities and traditional organisations of indigenous people, with their own forms of government, called Organizaciones Territoriales de Base. This distribution is done on a per capita basis, where every community works with its own census. Thus, women, small children, and old and disabled people, who usually did not "count" for the community, are economically as important as producing members, and are now taken into account. Registration of population data has gained importance for the community, since death means shrinking of the communal income, and child and maternal mortality suddenly show concrete importance. In one year, eagerly learning and very concerned authorities of formerly forlorn and forgotten places have begun to co-ordinate with incipient and insufficient health and educational services, whose doctors, nurses and teachers are compelled to shape up and respond to what suddenly has been recognised as enormous necessities and exciting challenges. Community leaders, politicians, regional and local authorities compete in small towns and villages as never before for the municipal elections to take place next December. The Church and NGOs are beginning to integrate local health and educational directories, participating together with the people, not longer deciding and carrying out projects only of their own, or under agreement of a very distant and unreachable central level

Changes will be slow, but increasing, because participation is no longer a theory, or something more or less grudgingly conceded to some members of the community who more or less agree and are useful to the projects, and for whom the projects in turn are useful. Manipulation and economical pressure, which may be direct or indirect, will be more difficult, since those who are placed to work will also be hold accountable for the results, which was not the case until now.

We believe that in this way health care could be sustainable through the community, even if the State, the Church and NGOs would still have to help with investments, partially in buildings, more or less completely with equipment and some material supplies, specially in very poor and small communities.

Democratising health development: the NGO's, church and state

Eddie G. Dorotan, M.D.

1 Introduction

Greetings of good health to all of you from the Philippines!

I would like to commend the organisers of this workshop, CARITAS Internationalis and CIDSE, particularly Dr. Jan Vorisek and Carol van Leeuwen, for gathering a dynamic pack of health activists from different parts of the world to discuss a very important aspect of health care: that of sustainability.
My task this afternoon is to present to you a paper on the roles of the NGOS, Church and State vis a vis our present health problems and challenges towards more sustainable health care.

2 Current health realities

In a recent Health Sector Review in the Philippines done by Herrin, et al (March 1993), the following major findings were noted:

2.1 Trends in Health Outcome and Determinants

- little progress in mortality reduction
- persistence of area differences in mortality levels and reversal of mortality trends in some regions
- the continuous burden of communicable diseases, with pneumonia, tuberculosis and diarrhoea still the major causes of deaths (I would add AIDS and the drug resistance tuberculosis as added problems)
- increasing problem of chronic diseases such as diseases of the heart, vascular system and malignant neoplasms

- poor nutritional status among pre-schoolers, pregnant and lactating mothers; micro-nutrient deficiency especially iodine and iron
- high rates of disability

2.2 Proximate Determinants of Health Outcome

- slow fertility decline due to low levels of contraceptive use
- decrease in prevalence and duration of breast feeding
- poor environmental sanitation

2.3 Macro-economic and Social Factors affecting Health and Health Sector Performance

- slow economic growth and continued high poverty rate
- slow structural transformation of the economy
- slow improvement on education

2.4 Health Care Utilisation Pattern

- low proportion of deaths with medical attendance
- increased pre-natal care but continued low post-natal care utilisation
- continued reliance on traditional birth attendants
- low level of preventive dental care

2.5 Health Care Financing

- low level of spending (less than 2%)
- defects in spending pattern
- medical insurance is still a minor source of financing
- health sector expenditures are financed largely by direct household spending

It is obvious, therefore, that the current health situation in terms of supply and demand of health services as well as in terms of participation in health is still far from what we hope for.

3 A vision of sustainable health care

We envision a sustainable health care that is equitable, empowering, effective and efficient.

We want to see our health workers and facilities equitably distributed both geographically and culturally among all income and social groups, providing ready access to health services and utilisation by the people especially the poor.

Likewise, we want to empower the people by achieving control and ownership of the means to their health through involvement, participation, commitment and responsibility in health.

We want effectiveness in health by doing the right things in providing health services and program that produce results in terms of health outcome.

Finally, we want efficiency with the use of the limited resources available in its maximum usage.

When all of these merge, we can say that sustainability in health care is doable and achievable.

4 Democratising health: participation and synergy of the key actors

NGO-State Relationships

A new strategic paradigm is evolving in development work, including health care. This paradigm involves the "critical strategic partnerships" among the different stakeholders that realises that resources are limited and that complementation and synergy are required for maximum results and impact.

But partnership and synergy is no easy task as different NGOS/Church and different States have different agendas and orientations.

In the past and to some extent until now, NGOS and the State have mutual distrust of each other. This distrust is worsened in areas where the development theories of NGOS and the State differ. But again, regardless of differences, NGOS are aware that they can not ignore the State. They can adapt one of the three modes of stances: to oppose, to complement or to reform the State. On the other hand,

the state is aware also that its laws and resources are not sufficient for development. Slowly they realise the distinctive role of NGOS in development: attuning the State to the people's concern; pressing the State to be more accountable; and, filling the "gaps".

In these crucial partnership building, distinctive roles of each actor must be defined.

Role of the State/Government

The State/government will always be the main player in health development. Three specific roles have to be assumed for significant results and impact:

1. The State should create the general macro-economic and intersectoral environment conducive to widespread enjoyment of better health and nutrition and greater protection through sustained significant reductions in the risks to health. This means strong political will to sustain household income growth, equitable distribution of wealth and incomes, improved education, environmental protection and political empowerment of the poor.

2. The State should effectively and efficiently allocate the resources by increasing public expenditures on health, reallocation of health funds and better management of public investments.

3. The State should establish key policies that will integrate public and clinical health interventions; promote efficiency in public and private health care service production, delivery and management; encourage participation of the private and NGOS in health care; promote appropriate health technologies.

The Role of NGO's

The NGOS, on the other hand, must be in the forefront of democratising health development. People involvement and empowerment in health care must be its central focus aside from service delivery.

At the micro grassroots level, NGOS should continue implementing their community based primary health care programs. It has been recognised that NGOS do reach the very poor, are efficient, flexible, full of enthusiasm and cost-effective.

But beyond "hands on tactical" approach to health care, NGOS must also influence health development of the macro level. Enhancing NGOS influence can be achieved in four ways:

1. Project Replication

Successful health programs can be implemented in different areas by different NGOS and even by the State. Failure should be documented so as not to be repeated.

2. Mobilising people's organisations through networking

Massive involvement of grassroots organisations such as farmers, workers, women in national health campaigns, such as immunisation, breast feeding, national drug policy and even protest actions against environmental degradation, and other programs/projects that are detrimental to the poor - these heighten the people's awareness and action for health.

3. *Influencing policy reforms*

Drawing on experiences from the field, NGOS can strategically influence the State through policy reform proposals that press for appropriate changes in policies, institutions, laws and programs that have direct bearing on the health of the people.

4. International Advocacy

NGOS can build coalitions with international agencies to support their lobbying for appropriate and necessary reforms at the national and even global levels.

Finally, the NGOS especially the Church, have roles in maintaining ethical standards in health care. Euthanasia, abortion, bioengineering, contraceptions are controversial real issues that must be confronted cautiously and seriously.

5 Conclusion

NGOS and the State must therefore see their distinctive roles and realise complementary functions if better health results and impacts are desired. Obviously, this is more easily stated than done but we know that we have to start now.

Towards sustainability of healthcare in peaceful coexistence with the healing cultures and traditions of developing countries

Rexford K. O. Asante

Introduction

Sustainability of Healthcare and indeed of all sectors is a relatively new concept in the socio-economic development literature and is frequently referred to by development economists, politicians, national and international bureaucrats. Even though a Swedish publication claims Norwegian Prime Minister Gro Harlem Brundtland when he used it in connection with a conference on the environment in 1987, this claim is questionable. For several World Council of Churches document dated 1976 onwards contain the term.(Howell, 1982; One World, 1980) There is however no question that the term has become in the recent times a very frequently used one in social, political, economic and health development circles. (The World Bank, 1984; Inform. Dev. Editorial, 1994.)

Today, development theorists and planners device sustainability as vital element of projects and programmes. Funding agencies demand it. Government officials and political leaders of recipient countries deem it at best a necessary nuisance and price to pay. Project and programme proponents dread it. Implementors in the field fake it. Evaluators investigate for it. And finally, beneficiary communities cooperate with implementors to act it out. Clearly, sustainability is a concern for many actors in the development arena even if from totally different motivations. The Council of Environmental Advisors of Germany correctly sums up the prevailing feeling about sustainability when in one of its periodic statements it says:

"... the comprehensive political objective of sustainable development has become a mandate of the international community in the pursuance of a forward-looking programme geared to meet the challenges of the common future of mankind. "

A healing and health care system existed in pre-colonial Africa that was almost eradicated by Western offences. It can be demonstrated that there was much that was valid in the traditional system, but equally there were some aspects that were harmful and needed reforming.

The course that the colonial healthcare system took to its present paralysis in some countries will be outlined briefly. The concept of sustainability as defined from different perspectives and vested interests will be presented and critiqued.

Questions raised by the concept of sustainability as variously defined, the policy implications, and the programming and activity directions and with what outcomes will be outlined and critiqued. Finally, it will be suggested that different actors in the health sector - donors, governments, churches, communities can and must work out together strategies for developing systems that respond to the usual and typical health problems for which the average third world individuals and communities seek help work when needed.

Healing, culture and traditions

Human beings as individuals and communities are instinctively drawn towards self-preservation (Bube, 1971) and develop, over time, a cultural heritage of healing to support their biological endowments (Tournier, 1965). Every culture no matter what its level of sophistication is, has a healing system for the maintenance and the restoration of health and vitality. Some of these are mental or psychological; others are substantial and yet others are mechanical but and still others of a spiritual nature constitute an important dimension. These dimensions in more literate societies have taken the form of modern scientific medicine and have so developed and so fine-tuned the technological explanation in biochemical, biophysical and mechanical functioning of the human body that their entire system of health and healing is based on these. (Mackay, 1974) Other systems such as Sarpong (1993) writing on the traditional etiological classification of diseases by the Asantes of Central Ghana writes about are based on a different set of beliefs about the human being this way:

"Therefore the causes of diseases are many - God, the ancestors, the divinities, destiny, a person's own misbehaviour, witchcraft, magic and last but not least, natural degeneration and disintegration of the body. The more dangerous diseases and the more inexplicable health hazards are attributed to the spirits which when offended or, in the case of essentially evil spirits, out of sheer malice, inflict disease on the victim."

". . . nothing can go well with human beings in society unless good relations are maintained between them and their fellow human beings and between them and the powers that control the universe. Broken relationships may result in sickness or even the death of an individual. Natural misfortunes such as droughts, epidemics, or locust raids, may also be attributed to broken relationships."

"The prevention and cure include the taking of herbs and roots as well as spiritual cleansing and the offering of sacrifices... fumigation, confession, good life... It is, therefore, clear that medicine and religion go hand in hand."

This kind of understanding of the causation of ill-health will naturally lead to the development of a system of healing that is a blend of art, empirical "science", myth and magic. (Meek, 1977) Systems such as these which differed markedly from the twentieth century scientific medicine became the target of attack under the Christian-colonial regimes that swept across most areas of Africa, Asia, the Pacific and Latin America and were rendered ridiculous, unacceptable and in many cases, downright illegal. In many countries, at the time of attainment of independence there were laws on the statue books they inherited from their colonisers against the practice of herbalism, witch doctoring, sorcery and traditional birth attendants even if these laws were unenforceable.

Healthcare systems in post-colonial times

In the euphoria of independence, nearly all the governments that took over from the colonial powers believed that everything was doable and loudly offered free health services.

Rapid expansion of the basic health services infrastructure to previously unreached villages and settlements was embarked upon to make modern health services available within walking distance (5-8 kilometres or 1 hour walking time). Basic health services operated by new local councils quickly proved unmanageable and ineffectual. By mid-1970s, national export commodity prices had plummeted. National debts had mounted. Governments were not able to live up to their socio-political commitments to provide free health care and education. New strategies were clearly needed to save face. Primary Health Care concept and movement came to the rescue. But in some ways it made matters worse. There were large numbers of trained healthcare workers everywhere without the tools and requirements to provide the care their now aware and demanding populace needed.

Healthcare reforms appear to be the answer now. Under pressure from helpers they are busy shrinking the health services infrastructure and inputs, investments and personnel. This means a return to the bad old days when healthcare facilities were nearly all town or city sited; when many a child was born by the roadside or on a truck on the way to the maternity clinic but ironically the bright and eloquent elite both national and international are on speaking tours telling the people how much better this would be for everyone. There will be free choice and market forces will see to it that things improve. In a way they are correct. By the late 1980s health services were only available in the city and at a high price. It is in this state of affairs in many developing countries that sustainability of healthcare facilities and programmes or sustainable healthcare has entered the debate.

What is Sustainability of (Or Sustainable) Healthcare?

Like all trendy terms that appear to add a certain attractiveness to writings and speeches in their time, sustainability as a term has shown a remarkable potential to be "all things to all men." This is clearly unacceptable as it clouds intelligent discussion of issues. Achieving some sort of conceptual clarity is therefore a major challenge in the study of sustainability.

Concept of sustainability

An unnamed Ghanaian Health Official quoted by La Fond (1995) articulates well what others interested in this subject often feel when he says: "Frankly, I am puzzled by the term sustainability. This is an issue which only came up in the 1980s". His puzzle is shared by Computer Word Perfect 6.0 Programme "Spell Check". The programme does not even recognise the word "sustainability" and persistently highlights it as a spelling error. In an effort to help a common understanding of this new concept, definitions have proliferated but alas with no agreement among them.

The lack of an agreement upon a definition is clearly illustrated by the following selection of some of the most frequently encountered definitions. The definitions are presented to aid raising awareness of the problem of differences in perception.

1. Agapitus et al (1995) define it as follows: *"Sustainable development is development which allows us to meet our own needs fairly without preventing future generations from meeting their own."*

2. United States Agency for International Development perception which ostensibly is employed as a working definition by many donor agencies states that*: "Sustainability is the ability of a health project or programme to deliver health services or sustain benefits after major technical, managerial and financial support has ceased."*

3. According to an OECD (1989) document, *"Sustainability is survival of projects and programmes after an initial period of investment - financial, physical, or technological."*

4. On the other hand, the External Aid Co-ordinating Committee in the government of Ghana Ministry of health expresses as its working maxim that:
   "Sustainability is an important principle to both the Government of Ghana and the donors but it probably does not mean the same thing to both. Usually donors define sustainability to mean being able after a period, to withdraw completely and have the system remain operational.

We must remember that Ghana is not a rich country and that for a while yet we are going to need significant external support. With this proviso, we have no alternative but to consider sustainability in terms of organisational development and systematic growth, confidence building and improved efficiency in the use of resources."

5. Yet another donor and recipient joint view that guides most bilateral and multilateral negotiations defines sustainability as

   "capacity of health system to function effectively over time with a minimum of external input."

6. sixth and a bit different definition of sustainability by Mogedal and associates (1994) is:

   "A health service is sustainable when operated by an organisational system with the long term ability to mobilise and allocate sufficient resources (manpower, technology, information and finance) for activities that meet individual or public health needs / demands. "

7. Badri (1994) provides a very useful and practical working explanation of the term. He dispenses with the benefit of economy of words inherent in one sentence summary definitions. Instead he opts for regarding a more utilizable working definition as an *"amalgam of indicators"* that have been developed over a period of more than a decade and arranged in a way that provides an analytical framework that helps observation, measurement and analysis to permit acceptable judgements.

8. Badri's framework of indicators of sustainable overall development is particularly useful model that can be adapted for studying sustainability as a field research exercise. The present writer presents a variant of it based on familiar and generally accepted principles of Primary Health Care. From that rationale and perspective, Sustainable Health Care system may be described as one that has certain desirable characteristics *that ensure indefinite continuity of health services that address the basic needs for health promotion, health maintenance and health problems management that ultimately lead to the attainment and maintenance of a high level of health status of a defined population.*

These desirable characteristics are:

i APPROPRIATENESS, because the system is based on accurate
- Demographic profile with built-in updating mechanisms
- Epidemiological profile with built-in updating mechanisms
- Health, health hazards and practice pattern

ii AVAILABILITY, in the sense that it has put in place a functioning system to respond to health problems that the people need to have addressed in
- Adequately organised, equipped and staffed facilities and programmes to offer level appropriate care technologies
- A hierarchy of care arrangements of increasing complexity and sophistication
- Dependable state of readiness to serve, to deliver expected services when needed

iii ACCESSIBILITY, in terms of
- Geographic coverage of the population
- Catchment (service) area size, distances, roads quality and communications
- Reliability of public (commercial and ambulance) transport at fair costs
- Skilled channelling and functioning of the referral system when needed

iv. ACCEPTABILITY, as reflected by
- Utilisation statistics i.e. outpatient visits, inpatient admissions and bed occupancy rates
- Patient compliance and follow-through of referrals
- Reputation and credibility of services: friendly caring staff, full stock of drugs supplies
- User satisfaction

v. AFFORDABILITY, as judged by
- General (local and national) economic situation
- Budgeting proficiency:
- accuracy of fiscal requirement

- fund mobilisation and raising plans
- fund allocation
- fund disbursement and accounting quality
- Cost consciousness in service delivery (cost per unit of service)
- User charges the average patient/client can comfortably pay
- Balancing of expenditure/income accounts including hidden and charity care accounts and funds
- User perception of value for money

vi. ACCOUNTABILITY as evidenced by
- Written vision / mission / raison d'être, goals and objectives
- Governance structure and functioning
- Management structure and quality of functioning
- Transparency and professionalism of technical operations (reports)
- Transparency and professionalism of financial statement and audited accounts
- Church health week/open day

vii. APPRECIATED AND VALUED community asset as indicated by
- Care about long-term fate of health facility / programme
- Clear expectations from health facility/programme
- Perceived by the people as a needed health facility / programme
- Local and national contribution to inputs and processes
- Human resources development and management to ensure local personnel dependency of facility/programme
- Reputation

From these few selected examples of definitions, sustainability or sustainable development means very different things to different people. Some of the definitions offered while useful as starters of discussions are hardly useful in empirical studies as they are non operational. In other words they neither help in categorising variables to be studied nor with the selection of measurable or observable indicators.
Clearly, then any serious discussion of sustainable health systems development must address the question of definition that satisfies all concerned quite apart from the substantive issues the concept raises.

Issues arising from sustainability

Even this necessarily brief discussion raises a number of issues and problems regarding the concept and work on sustainable development of healthcare which need to be raised and resolved

A few of these issues are presented here:

1. First, have the healthcare systems that are represent here evolved models that adequately address the needs, wants and demands of the beneficiary populations that are worth sustaining? If the answer is not yet, what is to be sustained? Shouldn't the mental energies and resources of governments, churches, academics and all be devoted to developing, testing and putting in place desirable healthcare arrangements that serve us well here and now and defer how to sustain them till later?

2. A lot of attention seems to be paid to the definition of the concept of sustainability of health care. Is a generally accepted definition worth striving for? Isn't it best to leave it to any negotiating partners to mutually define it the way they want the partnership to be governed?

3. External assistance that underlies all questions of health programmes viability and sustainability has a basic paradigm to it. It always subsumes a capacity to deliver adequate care deficit which can be made "better" but it is hardly ever clear from whose point of view?

4. Closely related to the basic aid paradigm is what La Fond (1995) has called the "Pump Priming" principle of aid to set poorer countries up for taking off on their own. But this in many donor favourite countries has been bedevilled by inter-donor competition in projects/programmes over-funding. This has thwarted self-reliance and sustainability of the programmes in question. In such situations donor mission staff popularity has been more important than projects or system sustainability in spite of rhetoric to the contrary. A conflict of goals or objectives situation results.

5. During implementation of particularly favourite projects of external aid bureaucrats' clear frustrations with recipient countries' slow rate of resources obligated (i.e. so called low absorptive capacity) is frequently heard. Is this desire to push for faster use of resources to achieve specified results not totally incompatible with sustainable development? Apart from achieving planned outputs and outcomes to add one more jewel to the curriculum vitae of programme officers of donor bureaucrats what viability have such approaches?

6. Sustainable healthcare systems development many would agree is a relatively new concept in development circles. It has come to be more consistently raised as a **development** criterion since the fall of communism and the ascendancy of conservative capitalism. It therefore may be wondered and with some justification whether this is not an ideological ploy. By ideology in this context is meant the structure of ideas and experiences created and promoted as guide to social action by the powerful to shape society to their liking. For example until recently the dominant ideology in relation to excellence in medical and healthcare was that it was like a pot resting on a three-legged stool made of Teaching, Research and Patient care. In recent times with the dominance of bureaucrats and shift of healthcare decision-making to economists, managers and administrators a different three-legged stool of Cost, Access and Quality of Care is what is being promoted. In the hands of a different dominant **group,** the power could be used to push perhaps a different stool made of Disease Patterns, Intervention Efficacy and Population Health Status for instance. It can therefore be open to debate whether or not the current concentration on sustainability is merely an ideological tool to promote the market orientation.

7. Yet another issue is the invasion of economists, managers, engineers and information specialists into the interface stage between biomedical/health sciences and their application to society. This invasion justified by arguments of trans-disciplinarity of biomedical science is permitting these increasingly powerful non-medical professionals go so far as to determining clinical competence models that ought to be transmitted to and be practised by future medical professionals. The question is: should techniques over-ride substance in determining what ought to survive, be retained in education and therefore be sustained in clinical work in the real world?

8. In the sphere of Healthcare Ethics and Morality, powerful political machineries have gone to great lengths to undermine and to prove that systems that attempt but certainly do not 100% succeed to provide healthcare to as many people as possible do not work. In spite of abundant evidence that shows that a measured bit of care for everybody benefits society much better than the best for a few, a new ethic and morality is being propagated. That ethic argues that providing anything less than the best possible in this day and age is both unethical and immoral especially to those who can afford and want nothing but the best care. Is that view in the interest of even the survival of any society?

9. Historically the church with its medical mission has until lately (even so not completely) assumed the position that God and scientific medicine are "light" and indigenous health care they encountered in "heathen lands afar" is darkness and harmful superstition and the church using its influence on governments did all it could to paganize, criminalize and to root it out. Now the tune is different. Many eminent church leaders are reportedly endorsing traditional healing and medicine as acceptable recourse open to people. The worrying aspect of this new stance is that the reconciliation of the erstwhile "darkness" with the "light" is not based on any credible studies but only on economic rationale. That reasoning is people are unable to afford high priced pharmaceuticals and fee-for-service medical care now forced on them and their governments by the dominant economic order, are therefore resorting to traditional medicine and so the church must accept and reaffirm this trend as compatible with Christian or church social teaching. This raises the question as to whether this a tenable and an honest position for the church to adopt. Is the church' s endorsement of traditional healing systems and medicine based on well-founded knowledge of their safety and efficacy or merely on their ready availability and cheapness?

10. The final issue to be presented here concerns the wind of health care reforms now taking place in most countries. Reforms of any kind entail significant redesign process that results in a deliberately crafted structure and rules by which all actors in the healthcare arena shall play their roles. Churches and para-church groups or organisation have always played key, if not leading roles, in healthcare.

But the nature, demands and technologies of care have changed. In spite of all these changes do churches feel able to continue providing services? If so should not they be fully involved in the reform processes? And if they should, what should they be contributing to the reforms in their respective countries?

Many more issues, problems and concerns could be raised as the nations represented here wrestle with problems of developing viable, appropriate and perhaps sustainable healthcare systems.

Setting healthcare systems agenda for the future

The pressure for health reforms in spite of all that is being said against them, has at least one positive side to it. That is, it provides an opportunity for reflection and review of past models of care of learning from them and planning for the future.

To date, too many countries of the Third World have allowed their healthcare systems to be donor designed and driven, have gratefully diverted government funds, of from budgets to other uses (not always positive or legitimate) and have operated systems to satisfy donors.

If present trends continue and donor funds continue to dwindle the governments and peoples and their respective countries are going to largely or even wholly pay their healthcare costs, they must call their own tune. Countries will have to realistically appraise and convince themselves as to whether they have time, place, and the epidemiological resources for appropriate healthcare systems in places that deserve to survive or are worth sustaining. Frankly, many do not. What they inherited from colonial governors were far more functional and efficacious than what they have thirty years after independence. It will be more realistic to reject sustainability of their existing systems as their priority problem and instead embark on developing new visions, missions, designs, strategies, plans and functional delivery of services that have incorporated all their past experiences. Developing viable systems with clear time schedules of reviews and deliberate phasing may be more appropriate tasks for some nations now. For others sustainability of an already sound existing systems may be what is needed.

Concluding comments

For many decades into independence many non-aligned Third World countries have had the good fortune to reap the benefits of political ideological divide between the super-powers in the form of development grants, loans and investments. This generous help was partly to enlist political support and partly to develop a potentially enormous buying power for their goads and services. Both motives have become irrelevant now. During the period of sufficiency of external aid, some of the things that were sacrificed were research into and advancement of indigenous healing systems, decision making and control over the newly adopted systems and the rate of their expansion.

In the last five years, there has been considerable pressure and encouragement to become more self-reliant. This has been done under the banner of the concept of Sustainability or Sustainable Development even though neither term has acquired any universally agreed upon meaning. As variously defined by various writers and speakers, sustainability is still a vital but confused term. To some it means the external funding 'party' is over. To others there is good reason to expect more coming to good recipients.

All of this mix of confusion, pessimism and hope raises several questions and issues, a number of which have been stated earlier. All those general issues and individual country realities and experience ought to enter into any considerations as healthcare systems development agenda are set in the years ahead. The really vital question is: Can countries of the Third World have the courage to accept the challenge to undertake this task completely unaided (Bossert, 1990) and thus be fully responsible and accountable for the paths they chart, the courses they follow and the results of their actions?

It is very apt as Christians to remember the lesson in self-reliance taught to the disabled man at the temple gate in Jerusalem which is called Beautiful when he perhaps as he had done all his adult life asked for donations from Peter and John as recorded in The Acts 3:2-8.

Peter said to him:
"Silver and Gold have I none;
But such as I have give thee;
In the Name of Jesus Christ of Nazareth rise up and walk."
And he took him by the right hand, and lifted him up
and immediately his feet and ankle bones received strength.
And he leaping up stood, and walked.

It is the Third World's lameness in terms of inability to bear full healthcare costs of their people that the World Bank Peters and the Bilateral aid Johns are challenging them to rise up and in full viability and sustainability walk with the rest of the countries of the world into the Temple of 21st Century Community of Nations, leaping with dignity and "praising God".

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Sustainable health care: human resources, managerial capacities and mutual inter-dependence

Dr. C.M. Francis

Introduction

Concern for health care is old. Interest in sustainable health care is of recent origin. Sustainable health care means the continuation of efforts at improving the health of the people, even after the external support is withdrawn. It requires building and expanding the capabilities of the people. It should bring about meaningful changes of indefinite duration in the lives of the people (1).

The central theme has to be continuous improvement in the health and quality of life of the people. For the poorest sections of the society, what is at risk is not the quality of life but life itself.

Programmes have to be sustained because most of the needs are likely to continue for a very long time, in one form or another; they are part of the human condition. But the need presents itself in specific forms, which change. It is necessary to find out what the form is and respond appropriately.

The degree of sustainability has been defined by Honadle and Van Sant (1985) as "the percentage of project initiated goods and services that is still delivered and maintained five years past the termination of donor recourses, the continuation of local action stimulated by the project, and the generation of successor service and initiatives as a result of project built local capacity" (2).

Sustainability makes little sense if it means sustaining health care that is below acceptable levels (3). The objectives should be to raise the health of the people to reasonable levels and then maintain and improve the health care. Programmes that perpetuate today's inequities are not sustainable nor worth sustaining.

Sustainability should not mean clinging on to what was being done irrespective of the outcome of the programme / project. There is need to abandon what no longer works, what no longer contributes, what no longer serves (4). Yesterday's strategies may not be relevant for today or tomorrow.

Assessment of sustainability of health care should take into account relevant impact of developmental activities in the other associated social sub-sectors also. These sub-sectors might be women's development, adult education, income generation, wasteland development, balwadis or anganwadis (5). These may yield higher dividends for better health.

Factors determining sustainability

There are two major sets of factors which determine sustainability.

1. Economic; materials.
2. Human resources; creative ideas.

The economic factors have always been important. They have become more so in the context of structural adjustments following the New Economic Policy. Economic growth will improve the health of the people only if it is available for and used to finance services for the sections of society that would otherwise be deprived of them.

New Economic Policy of India

Economic liberalisation has had an adverse effect on the people of all countries which had been subjected to it. The same is true of India. While there have been always the poor earlier, social security measures ensured that only one-third (34 per cent) remained poor in 1990.

With the reduction in the allotment of subsidies and less budget allocation for social services, the situation became worse.

In 1992-93, the second year of the post-liberalisation period , 40 per cent were found to be poor (6).

Table 1.
Percentage of people below poverty line in India

Year	Villages	Towns	Total
1989-90 (Pre-liberalisation)	33	36	34
1991-92 (Post-liberalisation)	39	37	38
1992-93 (Post-liberalisation)	42	37	40

This meant that there are about 360 million people in India who are extremely poor. It has affected the health of both urban and rural poor. Liberalisation has brought down an additional 54 millions below the poverty line.

The economy has made overall growth. Prof. S.K. Goyal, Director of the Institute for Study of Industrial Development put it this way: "It means people made more money : it does not mean more people made money".

The recent National Sample Survey states : The rich 20 per cent people earned more and bought more things, while the poor 20 per cent earned less and consumed less. This applies to health care service also.

The prices of all commodities, including medicinal drugs have gone up enormously. Even the price of coarse grains, the commodity of food used by the poor, has gone up very high.

Table 2.
Price of common variety of rice
(Price per Quintal)

1991	:	Rs. 289
1992	:	Rs. 377
Rate of change:		Rs. 30.4%

This increase is inspite of continued good monsoons.

The ration shop price of rice has gone up from Rs. 3.70 per Kg to Rs. 5.20 in three years, a rise of more than 40 per cent.

People could not afford the ration (Public Distribution System) shop grains, on which the poor depend.

Table 3.
Quantities of wheat bought from ration shops

Year	Offered for sale	Bought by ration card holders
1992-93	9.2 million tonnes	7.4 million tonnes
1993-94	7.0 million tonnes	4.4 million tonnes

Mr. P. Chidambaram, Commerce Minister, said at a recent seminar at Delhi:

- 300 millions have good jobs, good schools, and contentment.
- 300 millions have bad jobs, bad schools and hope.
- 300 millions have no jobs, no schools and no hope.

"The last category deserves help as the reforms won't help them ". Dr. George Mathew, Director of the Institute of Social Studies, Delhi, says "It is not just the bottom 300 million but the 300 million in the middle too are poor..... They too need help as do the 300 million at the bottom".

Human Resource for Sustainability

Why do some programmes continue to grow and develop, others merely survive and stagnate and yet others become inactive and even wind up ? Programmes and projects in health care are diverse. They have different focus and thrusts. The inputs, outputs and expected outcomes are different. These may involve primary health care, institution based health care or community health. The population affected may be different - the poor, the poorest of the poor, women, girl child or street children. Whatever be the nature of the projects or programmes, there are promoting and facilitating factors.

The most important resource in sustainability of health care is the Human Resource. "Sustainability denotes an in-built strength in the organisation to withstand the `slings and arrows of outrageous fortune' and move ahead" (7). This inner organisational strength can come only from the people. There is need to improve the numbers, quality and capacity of the people involved in health care. These include all the stake-holders.

Stake-holders

- The people (individual, family and community). They are often thought of as 'beneficiaries' or 'targets'. They are really the primary stake holders. They should own the programmes ultimately, if we think of sustainability.
- Voluntary organisations and volunteers. In recent times volunteerism is giving way to paid staff, looking for careers among voluntary organisation.
- Government (local, State and Central).
- Health professionals and workers.
- Trainees, trainers, educators, evaluators.
- Policy and decision makers.
- Funding partners.

Each of the stake-holders (constituencies) sees the programme differently. There is need for the full participation of all the stake holders in developing the **capacity** to sustain the efforts, so that even when external help is not forthcoming, the activities will continue.

A successful sustainability strategy is based on matching an organisation's internal capabilities with the external milieu in which it works. The internal capability depends mainly on the human resources.

Complex strategies

It is easier to work with the less disadvantaged (who have more resources to purchase services) than with the poorest of the poor for whom more complex strategies are needed. Sustainability is inversely affected by complexity. Our projects/ programmes should not be selected because they are easier to implement. It may be a good strategy to start with an easier part of the programme and then take up the more difficult components. It is also easier to deliver outputs, which are more tangible (e.g., increase in the number of hospital beds) and for which demand exists currently, though the real needs may be different (e.g., disposal of waste).

Qualities leading to sustainability

The success of any programme and its sustainability depend on certain qualities. The people involved in the system must have:

- a sense of **commitment** to the goal;
- **skill variety**. If the person has a variety of skills, he / she is likely to continue and, if necessary, take over when the other person is not available;
- willingness to work as a **team**;
- desire to accept and welcome **change**, when the situation changes; and
- **creativity**.

Managerial Capacity

Most programmes and projects which fail lack persons with adequate managerial capabilities. This failure may be in planning, organising, motivating or in responding to the changes needed as brought out in monitoring and evaluation. The situation changes continuously.

Change is the only constant on this earth. Good managerial capacity is needed to make use of the newer opportunities and solve the problems as and when they arise.

A good manager is good not only in problem solving but also in problem avoidance.

The managerial capacity should also include capacity to raise the needed funds from different sources, such that even if one source dries up, it is possible to sustain the programme from other sources especially the local sources.

Ability to mobilise increasing numbers of volunteers who give their services free or for a small honorarium to cover basic costs should be another managerial capability to be built up. The volunteers must be identified, inducted and trained. Volunteers from academic, professional, administrative and other fields can help in sustainability.

What then is required?

The most important requirement is capacity building. This must take care of the inputs, activities, outputs and impact. **Sustainable Capacity Building (Human Resources):**

Capacity building is a loosely defined term. It would include people, organisation and financial / material resources. Among them, the most important are the people.

We must have a fair idea of the current level of the capabilities of the people. We can then ask the question: What long-term changes in the capacities are required to bring about the desired changes in people's lives? Such capacity building should be achieved within the time frame of the project. It can then be reinforced, even after the project is over, to achieve sustainability.

Inputs (Stake holders)

Who needs capacity building? All stake holders. The people affected by the project/programme must realise from the beginning that at some stage, they will have to take over and 'own' the project.

The voluntary organisations must move from the position of service providers to catalysts and finally hand it to the people.

The voluntary organisations could help in sustainability, if they play an advocacy role. If the people can be made aware of their rights and demand those rights from the government, the programmes will have a better chance of sustainability.

The policy and decision makers and the funding partners should ensure that even when the plans are prepared, sustainability is built into them.

Activities (to bring about the outputs)

The activities would include people's training and education, people participating and organising, development of other stake holders, motivation, networking.

"Building self-reliance and leadership capabilities at local level is the most important ingredient for sustained development and progress in health" (WHO, 1988).

Outputs (what has happened?)

People are trained and motivated; they are organised to bring about the desired outcome; they have developed managerial capabilities for identifying the needs, prioritising, planning, organising, implementing, monitoring and evaluation; understanding the changed situation and the further changes needed. Other stake holders are developed as catalysts. Less dependence of the people on externals.

Impacts (Outcome)

Capacity built which would ensure sustainability. People developed to take over the projects / programmes. Other stake holders are ready to hand over the projects/programmes. Improved health care, leading to improved health, which will continue in the set or new directions.

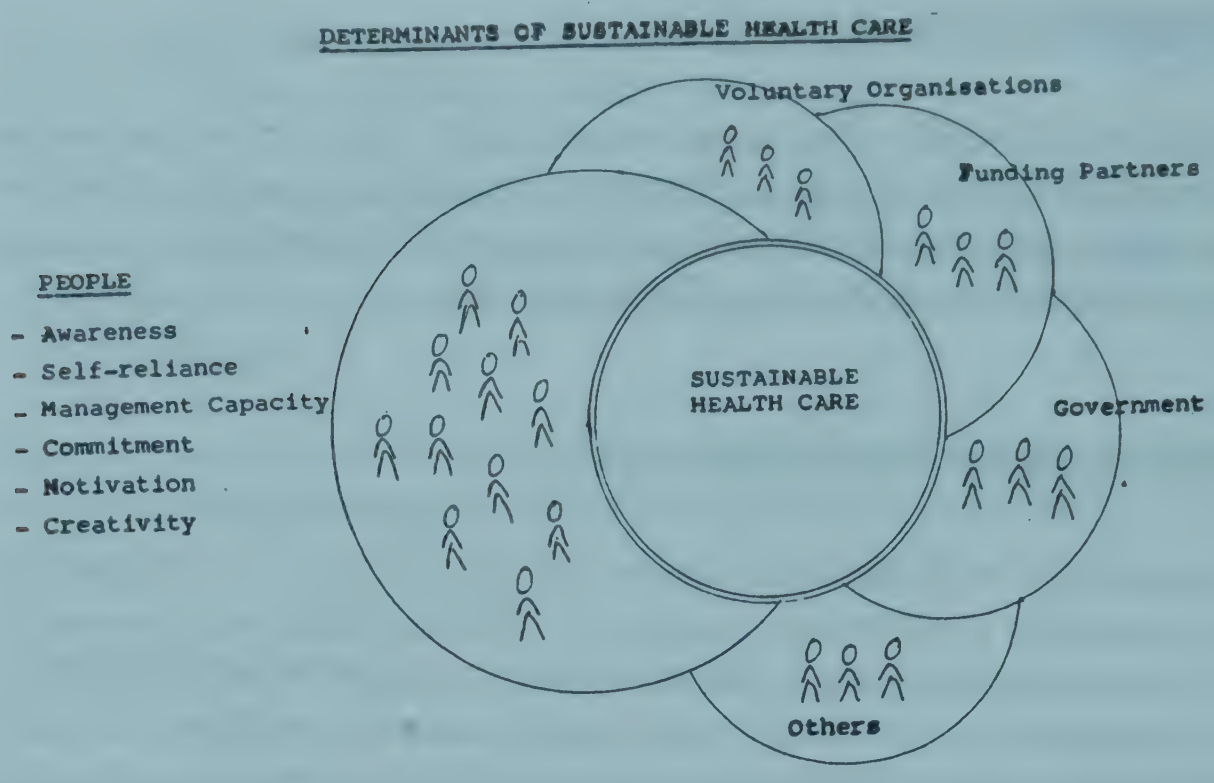
Community Participation

Sustainability of Health Care is enhanced very much by and is dependent on community participation. If a sense of 'belongingness' and 'ownership' is present among the people, there is greater possibility of self-reliance and self-determination. Community participation generates confidence and competence. Ultimately, they become policy and decision makers and implementers.

Participation may be of different types:

- Cognitive participation, identifying with the concept, idea or task.
- Process participation, leading to better decision-making.
- Interactive participation, educating, motivating and organising.
- Material participation, contributing by way of time, money, efforts or other resources.

Our capacity building efforts must ensure all types of participation. Ultimately, the community has to own and support the health action.



Ultimately we need a transformation from community participation in 'our' programmes to our participation in community's (people's) programmes. That will lead to sustainable health care.

The Mallur Health Co-operative

An example of a programme which has proved its sustainability is the Mallur Health Co-operative (8). There was a well managed milk co-operative in the area. The community was enabled to understand the health situation in the area by the St. John's Medical College, Bangalore. A tripartite agreement was reached between the Government of Karnataka (Dairy Development), St. John's Medical College, and the Milk Co-operative. Because of certain developments the Government dropped out from the scheme. The other two partners went ahead.

Together they set the goals and priorities, responsibilities and tasks.

The Milk Co-operative would provide 5 paise per litre of milk sold. This provided payment indirectly and in proportion to the income.

St. John's Medical College would provide the professional and technical help.

Together they organised the community to plan, implement and monitor and evaluate the programme. The Milk Co-operative provided a ready made collective leadership and management.

There was foot and mouth disease in the area. Milk yield declined. The co-operative changed to sericulture and continued to flourish. Members and non-members are entitled to all public health measures. Non-members pay for consultation. All pay for the medicines (essential drugs, limited in number).

The poorest are not members. They are sheep rearing or landless agricultural labourers.

St. John's withdrew from active participation about eleven years ago. The institution continues to provide advice and guidance, if and when requested.

Learning points

A health co-operative can flourish when added on to an existing, active co-operative. Community participation was assured.

There was built in leadership. There was integration into an established administrative structure.
The President and Secretary belonged to opposite political parties. They came together for the benefit of the community. Political differences need not stand in the way of development.

The context was economically and politically strong. It is known that weak economic and political context inhibits sustainability (9).

A growing organisation

If the sustainability of the entire system depends on the state of health of the Human Resources, then, management must look into the questions of human power planning. Many of the programmes come about as a result of the charisma of a single person or a group of persons.

It then attracts a wide range of people. The projects / programmes evolve and grow. The organisations grow. organisations are like living organisms. They are born, keep evolving, changing, growing and developing. They anticipate change. It leads to new ways, new approaches. Re-evolution takes place. Otherwise, the organisation may decay or die.

The inspired, charismatic leader(s), the founders, may leave. It is necessary to build a second line with leadership qualities and managerial capabilities. This becomes possible if there had been participative management in the organisation.

Most organisations have a reserve of skills and expertise than they can or do make use of. It is necessary to identify potential leaders and train them. This would give a standby of successors to replace key persons, should they become not available any longer.

An important part will be motivation. It is a process which is the most important determinant of human behaviour. Motivation is an inner state that energises, activates or moves and that directs and channels behaviour towards goals.

Pooling Human Resources

Shared services and managerial expertise can help in sustaining efforts for improved health care and reduce expenditure. This has been tried particularly with respect to institutions.

It has been shown in the multiple-unit health care systems. There is **centralised expertise** at the regional level with **decentralised management** at the local level, responding to the local needs and demands.

Sharing of human resources can be between all or some of the stake-holders, between the people themselves, between the voluntary organisations, between voluntary organisations and the government or any other. Government is likely to be major purchaser of care which
is provided by the voluntary organisations. It could bring about quantitative and qualitative changes.

Pooling of human resources brings about more co-operative relationships. It increases efficiency and effectiveness. It reduces cost. It increases the sustainability and growth opportunity.

Optimisation of human resources

An important contributory factor towards sustainability is the optimum use of human resources. Because the services are voluntary or at a lower cost compared to the Private Sector and even the Government Sector, we may not be careful enough to use the human resources optimally. There is need to ensure that the services of volunteers and others are utilised in the most effective way, preventing wastage of human resources.

Inter-dependence

If sustainability of health care is capacity building to continue activities resulting in further improvement of health, it requires inter-dependence of all the stake-holders. Dependence is disabling. Inter-dependence is enabling. It brings on synergy. The effect is more than the algebraic total.

Dependence of any one constituent on another takes away the freedom and ability to make one's own choices and policy decisions, in the particular context. It is harmful to sustainability.

The donor-recipient relationship is particularly prone to produce a culture of helplessness and dependence among the receivers and a sense of superiority among the givers. The relationship has to be more of a partnership in building a world that is better for everybody (10). Each respects the other, learns from each other and works in solidarity with all.

Preferential option for the poor

Humanity cannot advance in health unless progress occurs in the health care of all the peoples. There can be no real advance unless the poor, locally or globally, are enabled to lead a better quality of life.

The Preferential Option for the poor must be manifested in all our decisions about priorities in health care. Its aim should be to enable the poor to take life and fate in their own hands (11). Others should participate in the self-help process. There is need for equity with quality.

Justice

The idea of an inter-dependent community or world demands a more equal distribution of resources, reducing the gap between the haves and have-nots. It is a question of justice. By sharing with those who do not have, the haves are responding to their own innate needs for humanness and concern for justice, enriching themselves.

Inter-dependence means more. It is a question of recognising human dignity, the basis for human rights.

Love your neighbour

Inter-dependence in sustaining health care is also a question of love. Many thousands of years ago, the Hindu Vedas declared : Love your neighbour because you are your neighbour. What separates you from your neighbour is Maya (illusion). Whether we give or receive, we are one. We are all part of the divine, part of humanity. In each one of us is the Atman, part of the Paramatman.

Jesus has shown us the unqualified love for all humanity. He lived, proclaimed, suffered, died and rose again, showing His unconditional love for all humanity. He has exhorted us to love one another as "He has loved us".

Togetherness

There can be no superiority or inferiority but only togetherness. We are engaged in the struggle between the powers that enhance life and the powers that diminish life. We have to work together to change the forces which prevent or obstruct the Healing Power of God.

Together, inter-related, inter-dependent, we try to help the people, the individual, the family and the community, to transform themselves so that ...

they may have life,
and have it in abundance.

Conclusion

Sustainable health care requires human resources development and capacity building. All the people involved must be enabled to improve their management capability. Capacity building should be an integral part of the objectives and implementation of the programmes / project.

Sustainability should be considered in terms of continuing efforts for the improvement of the health of the people and not merely continuing what was being done, irrespective of the outcome.

The programme should be a people's programme. Ideally, the programme should be conceived, planned and implemented by the community, with all the other stake holders participating. The people should 'own' the programme / project. This should be a major objective of the voluntary organisations and funding partners.

There is need for building local initiative and leadership. Good administrative infrastructure helps. A politically and economically (income generation) strong community can lead to sustainable health care.

Programmes could benefit from shared central expertise and decentralised management at local level.

Sustainable health care is an issue of justice, human dignity and human rights. The health care programmes should focus on the poor. Economic liberalisation and structural adjustments have made more people poor, reducing their purchasing power.

Inter-dependence of all the stake holders, based on equal partnership, bring on synergy towards sustainable health care.

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Sustainable health care: technical and financial aspects

Frits van der Hoeven

For international donor-agencies Sustainability is like the weather: everybody talks about it, and everybody has its own ideas and solutions. A new hobby-horse. Without a reasonable perspective of some kind of sustainability, financial support will be questionable.
To a certain extent that is fair enough, all partners in development have neglected in the past this important aspect of our healthcare interventions, at whatever level initiated. However the situation is far more complex than sometimes suggested.

It seems a little embarrassing to talk about this sustainability when the macro-economic context is very unfavourable in this respect. A little more modesty would suit us when insisting on sustainability! For example:

The foreign debt in Sub-Saharan Africa amounted in 1993 $251.5 milliard and in 1994 $269.5 milliard. The interest and repayment as percentage of all income out of export was during these years resp. 28.8% and 35.4%. When we know moreover that the growth of the GNPO was 1.9%, the population growth 3% and inflation 33.6%, it will not surprise us that the African Development Bank concluded that all the programmes to decrease the debt burden have failed. On the contrary, despite all repayments, the debts have increased and remain an important stumbling block in all development processes.

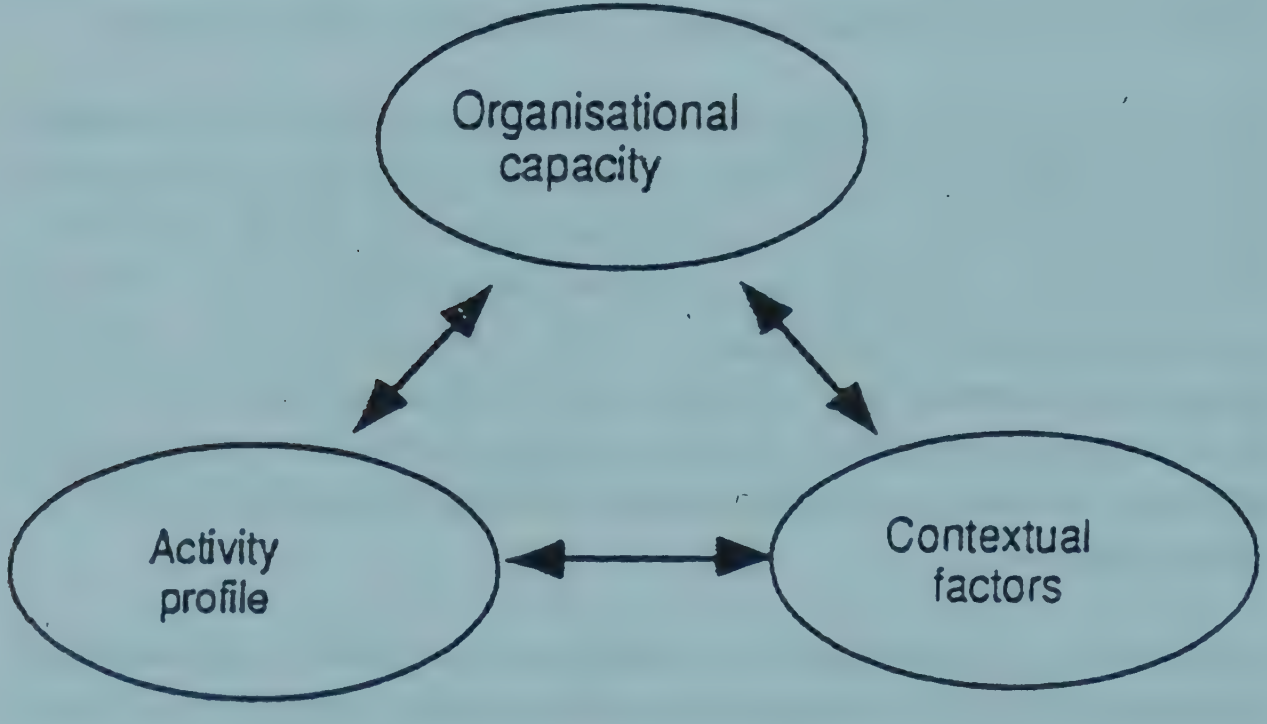
In order to focus our discussions I would like to use the following definition of Sustainability which has also been used by the Norwegian Mission Council.

"A health service is sustainable when operated by an organisation with a long term ability to mobilise and allocate sufficient resources (manpower, technology, information and finances) for activities that meet individual or public health needs/demands."

This definition makes it clear that sustainability has to be related to the level of health care and is certainly not only a matter of finances. Socio-economic, political, cultural and environmental factors determine this whole process.
An other definition like: "Sustainability is established when the continuation of project activities and benefits continues at least three years after the donor funding has stopped" suggests that sustainability is only a matter of financial support. An over-simplification!

Conceptually, the question of sustainability can be grouped in three clusters of factors which interact in different ways:

Factors related to sustainability

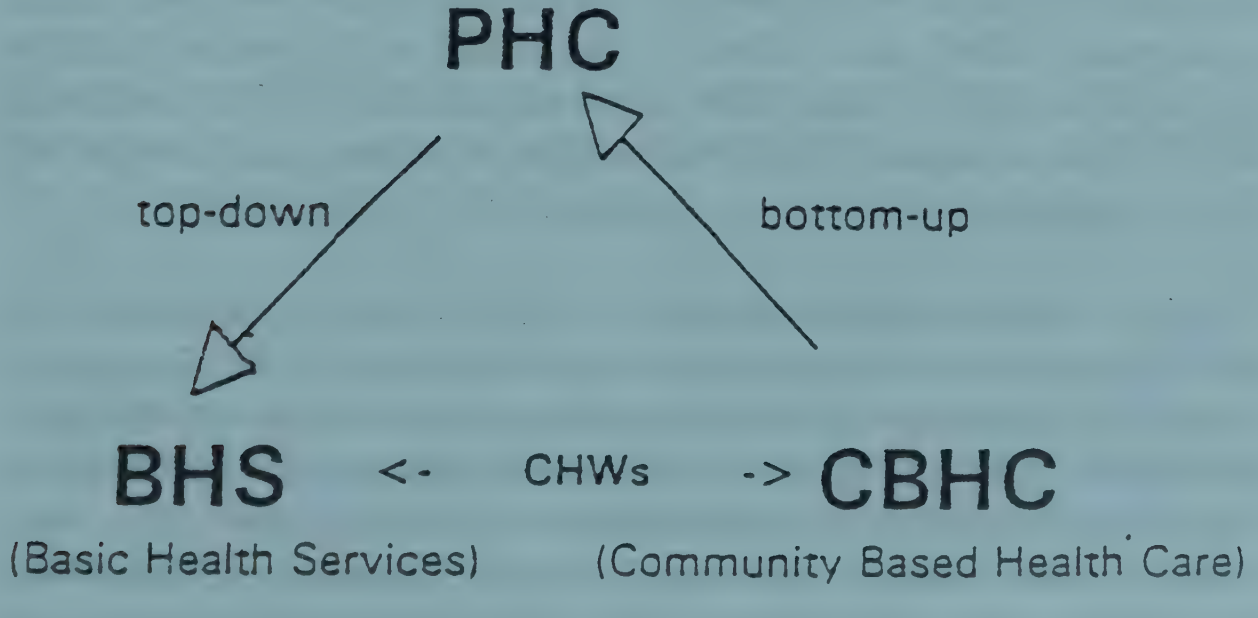


ref.: DIS, 1992

The main purpose of the organisation is to sustain its potential for producing certain activities. It is clear that this is subject to for instance its organisational capacity as well as contextual factors. Also the profile of activities might change according to contextual or organisational variations. Massive displacements of refugees in Rwanda have changed organisations and forced them to switch to completely different health interventions with a direct impact on their sustainability. Likewise has the AIDS epidemic in many places and many instances caused a complete change of objectives and operational policies, not foreseen when the project was submitted to the donor for financial support. Kitovu Hospital in Uganda, as we heard, is a moving example.

So the main conclusion sofar is, and that will not surprise us, that sustainability is a very complex issue influenced by many factors, often beyond the control of the project holder.

Now I want to focus a little more on one of the main areas of involvement of NGOS, certainly the Church related NGOS, namely PHC in relation to sustainability.
But first for all clarity and in view of all confusion around the meaning and definition of PHC I will give you our working definition: PHC is the combination of Basic Health Services and Community Based Health Care.
Let me borrow the model which Jan Vorisek uses and which he borrowed I think from me:



I think this picture can be useful to our discussions. It shows the interactions between BHS and CBHC and the linking pin function of the CHW, VHW or TBA. It shows the top-down next to the bottom-up approach.

As medical advisor of ICCO and a number of other Protestant donor agencies I am very well aware of the fact that in the passed decade our policy was very much in favour of supporting CBHC leaving the "brick and mortar" period, the building and renovations of health infrastructures more and more behind us. In the discussions about Selective versus Comprehensive PHC our position was clear: only an integrated comprehensive community based approach could have a sustainable impact on the health of the people.
The last years however we had to modify our policy. Many CBHC programmes, with CHW's and TBA's as main actors, more or less desintegrated due to a failing first line of referral. The absence of appropriate staff, drugs and transport made it impossible that grassroot workers were properly supervised, trained, logistically supported, let alone that they could refer their complicated cases for proper referral. We financed the training of Traditional Birth Attendants, they learned to detect the danger signs during pregnancy and delivery, they knew when to refer a woman for emergency treatment. Only, increasingly, the first line of referral failed to cope with these emergency cases due to lack of staff, drugs, transport, etc. Thus the TBA lost her credibility among her community as well as her faith in those who where there to support and supervise her.
Without denying the importance of CBHC, defined by equity, participation and empowerment, we realised that we had to retreat somehow, "reculer pour mieux sauter", and add next to the continuing support of CBHC an essential package of basic health services, including a good functioning small clinic or hospital. This should be part of an integrated, comprehensive health service programme. A process called "**contraction**".

Now it is very interesting to see that the UNICEF/WB/IMF have also passed through a process of adaptation, although not always in the direction we would like them to go! The previous policy could in many ways be characterised as SPHC, with its top-down, target oriented, technical, short-term interventions restricted to a few diseases and ailments, aimed at short term massive results, entirely neglecting the long term sustainability and effects. In its recent report of remarkable quality, **Better Health in Africa,** the WB suggest a new package of cost-effective interventions:

I Cost-effective package of health services
- basic package of health care inputs: essential curative health services
  essential public health services
- supporting services (IEC)
- intersectoral interventions (water and sanitation)

II Decentralisation of Health Care delivery

III Improved management of essential inputs:
- essential drug list
- human resource development
- infrastructure and equipment

In it self this is an interesting approach, which we as NGO and donor community certainly should not reject. It is interesting how the two parties, WB and its vasals at one hand and the NGO-non-profit sector at the other seem to approach one another in focusing on a more or less restricted input of essential services.
There is however a danger underlying the WB policies, which should not amaze us. Individual mankind has never been at the centre of their attention, instead modernisation and a market oriented approach strengthened by Structural Adjustment Programmes.
The danger of the WB approach is the establishment of a two-tier system: one level of health care to those who can afford it through a process of privatisation, and a far more inferior standard of health care to most of the poor.
Church related NGOS, who as I said before are forced to restrict their services also to a more or less essential package of services, must therefor aim at quality care, in addition to support of community based activities. In recent years more and more evidence is accumulating that the participation of community groups in the design and implementation of health and health related activities has a significant impact on success and sustainability. Therefor the community based approach should remain the main focus of our attention. Characterised, as Dr. Francis pointed out, by distributive equity, guarantee of a minimum of acceptable care and finally, quality assurance.

A second point which requires our attention is the decentralisation of services. Integrated district health care, with District Health Management Teams, is like sustainability a new popular topic and model within our development jet set. And many of our partners are for instance through their District Designated Hospitals directly involved.
Although I agree with the underlying philosophy and believe that such decentralisation can facilitate an effective, appropriate and more affordable health service system and could involve the community more in the process of planning and implementation, and can have a positive effect on the process of sustainability, we should be aware of the pitfalls!
Ideally decentralisation should lead to more intersectoral collaboration, more community participation and strengthening of management structures. In practice the reality is different: decentralisation is politically not a neutral issue, it usually means a shift in power-structures. A national government who tries to shift the burden of the responsibility for HC services on the shoulders of the district authorities without at the same time giving them the financial, technical and human resources to do so adequately. Or local power structures who, having now access to government resources through district management teams, built their own imperiums. But also the struggle of the various actors at district level to contain their own interests.

All of what I have said thus far serves as a kind of introduction to the subject which I have been asked to address: technical and financial aspects of sustainable health care which in itself can be addressed fairly straightforward, however bearing in mind the various reservations and comments made before.

Technical aspects of sustainability include a.o.:

1. Strengthening financial and organisational management
2. Strengthening the ability to mobilise and manage essential resources
3. Human resource development
4. Appropriate technology
5. Implementation of EDL
6. Management and maintenance of infrastructure/equipment/transport

It is clear that in this entire field many opportunities exist for financial support from donors.

Of course the financial aspects are slightly more complex and often seen as the predominant impediment to sustainability. Remember the other definition I mentioned.
There is according to me no doubt about it that for the coming 10 to 15 years most of our partners HC programmes will continue to face a structural deficit.
In the light of the economic recession, the negative impact of the SAP's on the social services and the population explosion, the financial situation of the projects itself nor that of the target population - mostly poor - will not improve. Perhaps for some optimists is there indeed a transitional phase as declared by IMF/WB and will the ultimate result of the stringent adjustment programmes lead to a better economic environment. Lets hope so. And let us hope that this would benefit the poor as well! If it should be the case then it is vital that our partners receive adequate support in the meantime to sustain their services during this transitional period.
Therefor it is very important that the donor community should consider to change their policy of not contributing to the recurrent costs of healthcare programmes. Structural deficits occur in the recurrent cost budget. These budgets are for an important part determined by previous capital investments financed by foreign donors. We should not forget that!
I think we could argue the case for recurrent budget support, provided that certain conditions are met which need further contemplation and discussion. One of the reasons that donors are very reluctant to enter into this type of budget support is the dependency it creates as well as -in view of the limited financial means of the donors themselves - the phenomena of "distributive injustice": the funds are all earmarked and there is no room for the financial support of new partners and new initiatives.

Mobilisation of local resources remains an important element. Although on average hardly more than 10 - 15% of the recurrent budget can be covered by the income from "users-fees" it is also established that the lower in the health pyramid the higher the percentage which can be covered by fee collection.
There is a lot of discussion about introduction of fees. I do not think in this forum I have to repeat all arguments, when your clientele are predominantly the very poor, it seems the last desperate measure to take. However I think it is inevitable and moreover could have a positive impact after all.

Research has indicated that a substantial amount of the household budget, however small this may be, 'disappears' to all kinds of health services in the private and traditional sector. Re-routing of this money to quality regular health care, whenever indicated (there is much to say for advocating traditional health care!) could contribute to a more sustainable health care. The following sheet shows the trends in the utilisation of healthcare services after the increase of fees in a number of countries.

Trends in Utilization after Fee increases

	Increase in Utilization	Decrease in Utilization
Francophone	Benin, Burundi, Cameroon, Guinea, Mauritania, Senegal, Togo	Burkina Faso
Anglophone	Sierra Leone	Gambia, Ghana, Kenya, Lesotho, Mozambique, Swaziland, Zambia, Zimbabwe

SOURCE: Nolan and Turbat (1993)

It is suggested that the health programmes in Anglophone Africa are more characterised by a bureaucratic and centralistic approach which seems to be not conducive to very cost-recovery. At the other hand, many of the projects in Francophone Africa are small scale and received substantial foreign support.

The reality however is that many programmes do show a decrease in attendancies, esp. from the poor, after fee introduction. And it has become clear from research of an impressive number of programmes, that unless certain conditions are met, fees indeed will create a tremendous problem for the poor. Decisive pre-conditions appear to be:

- community participation in the planning process
- quality of health services:
- availability of drugs
- attitude and experience of staff
- waiting time, etc.
- retention and re-investment of collected fees
- proper administration and management support structures
- possibility of exemptions

Most of our partners in health in developing countries are involved at the lower strata of the health pyramids: district hospitals, clinics, dispensaries and community based activities. In many ways their activities are complimentary to those of the national, regional or local government. Usually there is some kind of financial support from the government, but mostly insufficient, declining and moreover highly unreliable.
Resource mobilisation through users fees, cost sharing and income generating activities will be increasingly important. The quality of the services will prove to be decisive.
If this quality cannot be guaranteed than contraction of services should be decided upon: decreasing the number of beds, closing wards, terminating certain outreach services, etc.
I quote from the working document for the coming Vastenaktie/Cebemo/ICCO consultation in Malawi:
"If the churches and NGOS provide services that are not financially sustainable, than they should be prepared to cut them down to a size which allows for financial sustainability. Churches and NGOS should be extremely concerned about offering relevant and sustainable services of accepted quality. If churches and NGOS fail to provide such services, it would jeopardise all the faith people still have in being organised in communities. Therefore, it is probably better to trim down unsustainable services rather than to provide services which do not meet the people's essential needs and will inevitably cause disappointments.
Foreign resource agencies which support basic social services should be prepared to enter into long-term funding relationships, so that churches and NGOS that are trying to upgrade, reform and consolidate their services are assured of 5 - 10 years of funding."

Many developing countries find themselves in a transitional phase:
From a situation dominated by a high mortality and high fertility, to one with a low mortality and low fertility. Some countries are progressing remarkably well, others are dangerous close to what dr. Maurice King called the "demographic trap" where due to a decline of the mortality but continuously high fertility the environment cannot sustain its population and mortality ultimately will rise to levels higher than before.
In S.S. Africa however the situation of high mortality and high fertility continues, compounded by an increasing number of so called "solution resistant problems" I mention the AIDS epidemic, malaria and tuberculosis.

But also the staggering refugee problem and ethnic violence can be mentioned.

We all know that the social services in many of these countries are suffering the impact of the SAP's (Ghana expenditure on health care from '78 - '88 decreased with 47% . In Ivory Cost this was 43%!), and that many of our partners in health face tremendous problems in sustaining their activities.

Conclusion

I argue and put it for the discussions in the working groups, that the donor community must increase its efforts to improve the sustainability of healthcare programmes of their partners by:

1. contributing to recurrent costs
2. long term financial commitment
3. support and facilitate technical aspects of sustainability (see before)
4. support no capital investments without guarantees of recurrent-cost coverage
5. lobby/advocacy/network support in the West

From their side our partners in health care programmes should

1. strive for quality care
2. put every effort in raising local resources
3. contraction/consolidation of services if indicated
4. integration of services
5. support lobby/advocacy networks

In all of this mutuality in mission and relationship is of crucial importance. Its a two-way traffic between partner and resource-agency. Its a process of dialogue and relation building. The responsibility of the resource agencies as I see it is to support their partners in the process of creating an enabling environment, in which they can maximise the care for the poor and empower them as much as possible.
The responsibility of good stewardship over the funds entrusted to them.
The responsibility within their own society to stand up and fight for a just and peaceful world which is sustainable for mankind.

Participation of the marginalised sections of population in sustainable health care

Dr. B. Claus

The objective of this report is to respond to the alarm sounded by the Director General of WHO, who in his last report, 1994, stated:
It is necessary to address the inequalities increasing the gap not only between the rich and the poor but also between the poor and the poorer - those who do not have access to health care and those who are excluded from it.
He went on:
the means exist; what is missing are the programs...
It is for us to identify these programs and work on their implementation.

I What is a Just Society in Terms of Health Care?

There is a tendency to respond that the just society is one where the institutions are organised to give the greatest satisfaction to all its members. Another of the goals is to make sure that the majority of the population enjoys a well-being that is constantly growing.
However this principle creates a marginalized sector that is often not seen as having the same rights and opportunities. All persons have the right to the same freedoms and opportunities.
In order to provide the more disadvantaged members of society access to health care, we need to make them, instead of the population as a whole, a priority in all the action we undertake. The differences in the advantages of medical/health care are only justified if they contribute to improving the conditions of the less favoured (Mt 25).
Our action in the field of health care should aim at the disadvantaged first of all. They, as all persons, have the fundamental right to health care. We must make sure that our action is open to all and contributes to resolving our society's priority health care problems.

II How can we provide the fundamental human right to health care to the disadvantaged peoples of Africa?

A health care program with a good cost-effect ratio aims to guarantee better health conditions at lower costs.
In our opinion it is possible to improve the health conditions of families and other groups in different complementary ways.

1. Programs must be conceived in an effort to treat the priority health problems of the target population.
   We must identify these problems and the action to take that will allow us to be more effective against them. This action can be preventative, curative or promotional.
   The solution of these problems should be done as part of a basic health care program and integrated into efforts to improve the target group's overall welfare.
   Parallel vertical interventions that risk interfering with each other must be avoided.
   The priority health problems in Kinshasa are:
   - malaria
   - illnesses that can be vaccinated against
   - malnutrition in children under 5 years.
   - fertility-related problems
   - diarrhoeal illnesses
   - tuberculosis
   - AIDS

   Example: action against measles in Kinshasa

2. Secondly, it is a case of decentralising health care services and making them more accessible to the population. This has taken place principally through the expansion of the network of health centres and having a general hospital in each district of 150,000 inhabitants.
   These health centres provide basic health care services and resolve 90% of the problems at prices significantly lower than the hospitals.

As their target population is an identified group, the centres can evaluate their performance with regard to the people they cover and organise their activities accordingly.

Example: National Health Care Strategy. The Creation of Urban Health Care Zones in Kinshasa.

Zaire's national health care strategy is based on the development of health care zones, in English speaking countries called Health Service Area's (HSA's). The urban health care zones in Kinshasa are the operational units that implement the national strategy for basic health care.

It is directed by a zonal medical director. The zone comprises all health care services regardless of their administration.

It comprises health care centres (one every 15,000 inhabitants) and a general hospital or medical centre (one every 150,000 inhabitants).

The health care centre's employees manage the centre along with the health commission, which is made up of representatives of the population.

The zone's population is registered with the health centre (HC).

The team offers the population curative, preventative and educational health care and the re-education it retains suitable, keeping in mind the individual cases and the available and obtainable resources.

The HC team trains volunteer animators to promote health within their own families.

The HC must finance itself; however, given the current national situation, it cannot operate without subsidies.

3. Thirdly, a number of fundamental health care factors must be improved:
   - access to essential medicines
   - access to competent, motivated and adequately paid personnel.
   - access to specialised infrastructures with proper equipment.

   Example: The "health complaint to treatment" strategy for basic health care in Kinshasa.

4. To maximise the effect of the reinforcement of basic health care services, we need to accompany this process with a wide scale program of information, communication and education aimed at the target population.

The other objectives of this program will be to improve detection, exactness in diagnosis, acceptance of proposed treatments, the decrease in irrational demand, the response to the population's needs and to increase meaningful contact between health care providers and their patients.

This support service should not be undervalued. Education must concentrate on the education of the female population. The survival of children depends on the mother's level of education about and her participation in health activities. The mother is the most important health care worker for their children.

Furthermore, we must consider groups' cultural backgrounds. We must make the effort to involve families and groups in health-related activities in order to completely cover their health needs and to promote health-friendly attitudes.

5. Health is not based solely on income. It also depends on the creation of a healthy environment.
   Basic health care would also benefit from increased attention to intersectorial actions, in particular in the areas of:
   - the construction and utilisation of water purification plants
   - the decontamination of the environment
   - the development of activities guaranteeing food safety, especially regarding the cultivation of gardens and domestic animal breeding in urban areas
   - the spacing out of births in order to offer the child and the family better chances for their integral human development.

   In order to promote equality, we need to pursue programs that touch a wide range of the population, that guarantee them food, drinking water and a healthy environment. We can see similar action in the fight against malnutrition and diarrhoea.

   Example: Combating malnutrition in Kinshasa
   Education of those affected by AIDS and protection of groups
   Fertility supervision in Kinshasa

6. Mobilising resources to finance health care improvements:
   - Expenditure allocated by the public sector should be increased.
   This expenditure should be channeled to first or second level basic health care services and not solely to hospitals.
   The population must cover a certain amount of the costs involved in their care. The poor must be identified so that they may benefit from subsidies.
   Donations must be encouraged and progressively increase the financing of basic health care (curative, preventative and promotional).
   The finances should be used according to the needs identified by local health workers; they should not concentrate on a particular sector arbitrarily considered a priority.

   A 1994 World Bank study on low income African countries calculated the cost of a national health care program at approximately $13 per inhabitant per year. This $13 would break down as follows:
   - services of a basic health care program = $7.74 per year
   - cost of intersectorial interventions = $3.98 per year
   - cost of support services = $1.50 per year

   These costs would have to be adapted to the socio-economic context of each country.

Conclusion

International solidarity must invest in collaboration aimed at guaranteeing the welfare of poor populations. This welfare must make heath care geographically, economically and culturally accessible to populations as a whole by favouring the poorest sectors in view to achieving "all for health and health for all".

Case studies

Establishment of health action groups and education of NGO staff in PHC,

Experience with Health Care from Mexico

Guadalupe Alejandrina Cabrera Muñoz,
Jesús S. Reza Casahonda

We thank the organisers for the opportunity to share the Collective for Health Information and Education (CEIS) of Mexico's 11-year experience of grassroots health education.

We decided to participate because we think it is necessary to listen to all those involved when speaking about the contribution of health care systems to sustainable development, especially in view of the idea of true human development being achieved in a just and dignified manner.

This report contains guiding elements for the construction of the **new political environment** necessary for sustainable development. Considering **community groups** designers and the implementors of their dreams is the basic principle of the educational proposal we are presenting. We think that by continuing to decide for others and forgetting the human ability to create and build the path towards a better quality of life, we are perpetuating the **development of underdevelopment.**

This experience is taking place while great changes are occurring in he world: the fall of the Berlin Wall, the war against Iraq, disintegration of the left and a lack of ideas, the break-up of the USSR, the realignment of global economic blocs, etc.

Latin America has experienced the end of the dictatorships, the fall of popular governments (such as in Nicaragua), the signing of peace accords (in El Salvador) and the continuing isolation of Cuba.
At the same time, the largest market in the world (300 million consumers) was inaugurated with the signing of the NAFTA.

At that moment, the previous century's **concept of citizenship** reappeared. This is the concept by which an individual's existence depended on his ability to buy and consume, leaving by the wayside a large section of the population that **did not have this ability**.
Many persons, intellectuals, social groups, political movements, etc. began believing that there was a **true Utopian crisis**, a disappearance of hope, a loss of the right to dream. The mass media continued to announce an era of abundance for consumers while our governments shut down services, becoming mere managers of the scarce national resources we Latin Americans posses.

The crisis of Utopia and the disappearance of hope became the property of a few people, while the masses of poor people could not afford to lose the little they had - **dignity and hope**.

There is little written on history of groups who **created collective groups for participation and empowerment** in this period. Only a few Latin American NGOS documented popular experiences in the social sector, in the areas of services, production, human rights, etc. They were grassroots empowerment groups that realised projects, workshops, networks and publications.

Not all these experiences created empowerment groups. Some were not intended to do so. Other reproduced the framework for project implementation used in Latin America's "Alliance for Progress" of the 1960's. Despite the errors made, they did not give up in their efforts to raise the people's quality of life, even at this "micro" level.

When we speak about sustainable development, defined by the Global Commission on Environment and Development as being that which "satisfies present needs without limiting the potential for satisfying the needs of future generations", we embark on a discussion of environment, populations and economic models.

This experience will deal with population, not as merely another resource or a destructor of the environment, but as a conscious, critical intermediary of solution-oriented proposals. The poor refuse to be excluded and propose solutions; they do not accept the blame for the destruction of the environment through their mere existence.

The country's present health status

The poor must organise to resolve concrete health problems with, without, or in spite of health policy. The illness and death rates of these social sectors were the catalysts for the elaboration of the educational proposal as they were different for the majority of the population.

During this period, the behaviour of illnesses underwent changes that effected the population's health. Health problems related to poverty such as infectious-nutritional illnesses were joined by chronic degenerative ones, accidents, increases in deaths by AIDS or violence in areas and sectors of the population where they had not previously existed.

We used health indicators that serve to monitor the direction and speed of development. For example, **infant mortality** is 4 or 5 times more frequent among the poorest sectors than among the wealthy. There is up to a 15-year difference in **life expectancy** between some social groups and others. **Maternal mortality** in some of our country's states such as Oaxaca and Chiapas are double the already high national average. Easily treated illnesses become a serious health risk for the poor.

As a result of the decrease in the consumption of meat, milk and eggs in the period 1982-1990, there was a rise in **malnutrition**. 40% of children never eat these foods and malnutrition among under 5 year-olds has increased.

During this decade, Mexico has suffered epidemics of diseases that had disappeared, such as cholera, a disease that has taught us the relationship between illness and poverty.

Malaria, a major public health problem during the 50's, re-emerged as the resources dedicated to combat the disease decreased. In 1989,**measles** caused an as yet undetermined number of victims.
During the period 1982-1990, the greatest cause of death for men aged 14-44 was **accidents and violence**. This year, these causes were joined by suicide, which is a problem related to mental health of the population.

Overall, this image of illness and death expressed the changes in the application of market economy policy which called for the transformation of the welfare state into a neoliberal state.

This change has caused a deterioration of the public health service and the increasing privatisation of health care services. Deterioration refers to the 15 million Mexicans without health care coverage, that is, the 30% of the population deprived of its constitutional right to health care.

The channelling of finances away from the health sector is a continuing phenomenon that has accelerated in recent years. Per capita health spending has fallen drastically, forcing governments to offer a minimum service package that does not guarantee the fight against the principal causes of illness and death.
Here follows an overview of our experience in these times.

CEIS' (Collective health information and education's) experience

Actors
The experience of personnel education for non-governmental community health project development began in 1985 with the identification of areas where the four principal actors could be found.

1. people involved in the Church who were trying to transform their Christianity into a practical function in the service of the community, in view to contributing to the construction of a new Church.
2. people suffering the effects of decisions on health care and people who wanted to play a more active part in the "use" of their bodies and to change the doctor-patient relationship. They wanted to "stop being patients".
3. a team composed of health care professional who wanted to effect a change in the doctor-patient relationship, to de-medicalise health care and to empower the people so that they could exercise their right to an opinion on the "use" of their body and the health of the population.
4. less prominent actor was the government health services, which, in the mid-80s, introduced the element of social participation at the same time as it cut public financing of the health care sector; it saw social participation as a way of cutting costs and delegating responsibilities.

Process

There were four stages in the education of personnel for community health projects. Each one had the goal of promoting democratic processes in which the population, especially those "without a voice" would do the decision-making regarding their individual and collective health.

1st Stage (1984-1985) Alternative Medicine Workshops

Acupuncture, herbal remedies, homeopathy workshops for the general public were geared to reducing medical care costs and to opening possibilities for self care. This proposal had a good response and put us in contact with other NGOS who were going in the same direction and were creating networks for support and exchange.

Nevertheless the project was in itself limited in so far as its activities were directed towards an individual or sometimes family, but not towards a community.

2nd Stage (1985-1987) The group of professionals formulated a programme for training of health workers ("promotores").

Workshops were aimed to offer responses to illnesses related to living conditions (homelessness, lack of public services, malnutrition and poor working conditions) and to contribute to reorientation from the individual practice of health to a community health service. The health workers trained in this stage were intended to be able to resolve primary health problems, to analyse collective heath problems and to have organisational ability in order to set up short and mid-term preventive actions.

Participants in this stage were persons interested in resolving problems on an individual level and putting their knowledge to use to solve principally curative problems.

Nevertheless, they encountered management problems requiring new organisational skills in order to train local health teams (approved by community's decision-making bodies) to reach out more effectively the community.

3rd Stage (1987-1993) Programme of education of health workers ("promotores"), production of education materials

This stage received a greater response; there were more applicants from small organised groups from rural indigenous areas of less than 2500 inhabitants without health services but supported by a organised groups within the population.

Also general education materials with governmental and non-governmental institutions were made. Finally, limits of NGOS and the relationship vis a vis the government were defined in order to avoid that their activities take over the government's responsibilities regarding the health of its people. The results of this stage were promising, despite the fact that some activities had to be redefined and weak points be strengthened. Nevertheless, the success of this stage did not depend on the education processes and continuing technical education only; it promoted mainly groups' organisational skills.

4th Stage (1994-1995) Training of Popular Health Educators
Projects grew in coverage and personnel, and new challenges arose, such as:

1. maintaining quaiity in curative care;
2. project co-ordinators performed too varied types of activities, principally education of the public and training of new promoters;
3. education was done in an automatic manner, copying the training program for basic health promoters without including analytical elements for the adaptation to specific local needs such as: technical skills of the community; education in consideration of people's culture, that is, adapting educational processes to the lifestyle and pace of different target groups;
4. deficient curative care, limited effectiveness of co-ordinators' activities due to their multiple tasks and the vertical educational relationship did not ensure people's critical and effective participation.

For the above reasons, from 1994 e new popular health educator programme was designed and implemented to respond to these problems. Its methodology included the concepts and philosophy of popular, e.g. non-formal education as well as educational techniques for work in open communities and the training of health promoters. In the educational process, the educator's duty was to balance the curative and educational aspects of the health promoters training programs.

The last stages involved approximately 400 health promoters, 30 popular health educators, 25 health project co-ordinators principally from central and south Mexico. In total, the programme assisted in training of personnel of 11 non-governmental community health projects.

As you have heard, the positive results of each stage depended on previous errors and capitalising on the strong points. The health action groups did not depend on one single person. The proposals concerning future line of action did not come from persons with superior technical knowledge, but rather they were collective creations. Formation served as a lead to tell the story of own experience and to touch on elements that contributed to the education of the groups.

These years' experience taught us the basic aspects needed for educating health personnel:

- Establishment of health action groups depends principally on organisational factors; those rooted in their communities achieved the best results;

- Broadening knowledge on health issues of the action groups is necessary for appropriate, better adapted formulation of the programmes;

- Health action groups, as a result of dialogue, socialisation and identification of the health problems, will feel responsible to solve them as a common issue;

- Health education based on the daily experience of the health action groups with curative, educational or organisational issues, will use approach according the people's needs;
- Health action groups can break professional's monopoly of medical power and put it in the hands of the community;

- Health action groups, if they truly form a collective and belong to the people, will reflect democracy in its structures, daily operation and plans;

- Democracy exists when everyone has the same opportunity for information and participation;

- Education of community health program personnel cannot be limited to the dissemination of easily-learnt theory but must aim at the transfer of practical skills that will ensure the project's survival on its own;

- Analysis of health-illness relation of peoples from the socio-historical aspect is needed, meaning that "man becomes sick and dies depending on the way he/she takes part in the productive process", superseding biological and ecological vision of health in order to be able to propose a plan of formation that could eliminate the origins of illnesses;

- Creation of health action groups permits to avoid adoption of well-intended proposals of "others", of those who do not know these problems. It also will work towards forming bonds of solidarity with those willing to build an "ourselves".

Sustainability of health care in times of AIDS, experience of Kitovu Hospital, Uganda

Sr. Mary Teresa Reilly, M.M.M.

Introduction

In this paper I would like to argue the point that sustainability is about selfreliance and that when people are ill they are unable to be self-reliant.

Instead they are financial and social burden on society. Therefore, providing curative health services is essential to sustainable development.

1. Uganda Statistics

This presentation is made against a certain background; that Uganda is the fourth poorest country in the world; that it has a foreign debt of $2.6 billion, most of which was given during the reigns of Amin and Obote; that between 1993 and 2010 Uganda will pay $3,000 million servicing that debt (they paid $100 million in 1993) and that AIDS has severely compounded the already present problems of poverty.

More than a decade has passed since the first cases of AIDS were identified in Uganda. To-day, approximately 1.9 million Ugandans are estimated to be infected with HIV out of a population of over 17.5 million people, that is 10 - 12% of the total population. In some of the urban centres the rate is 35%. During the next 5 years, 1 million more people may be infected if preventative activities are not increased and become effective. Of those already infected many will develop AIDS during this time frame.

It is estimated that in 1998, 340,000 persons with AIDS will need care, far exceeding the capacities of the Health and Social Care systems. Presently Government estimates that there are 1.5 million children who have lost one or both parents.

Co-factors for increasing AIDS spread in Uganda include Multiple Sexual partners; Presence of other Sexually Transmitted Diseases and gender reality problems.

Research done in Masaka by the British Medical Research Council, shows that the progression from HIV to AIDS is much higher that we had thought. 11.6% Of cases developed from HIV to Full Blown AIDS and died within the first year. Another 23% progressed from HIV to AIDS and died in the second year. This is 2 to 3 times faster than what has been documented in the Developed world. Why this is so is not yet clear.

In June 1994, 46,000 cases of AIDS had been reported to the Ministry of Health but the Ministry estimates that the actual number of cases is around 300,000.

2. Theme: sustainable health care

This workshop is about sustainability, but what is the definition of this much used word? Many papers have been written on this theme but there seems to be a lack of agreement on what it's actual implications are. Studies in the late 1980's by the World Bank and USAID showed that up to 80% of the projects reviewed were in difficulty in relation to sustainability. It is probably true to say that most projects fail due to lack of funds for recurrent costs. I agree with Peter Poore of Save the Children Fund who says "There are no short cuts and no easy answers to the problem of sustainable health care delivery." My own experience in the administration of health care services both in Ireland and in Uganda and other African countries indicates that every hospital which provides services for the general population incurs a substantial deficit and is therefore not sustainable without financial input from Government or other outside Agency. To quote Peter Poore again "Those with special needs not provided by States will always be here. Responding to their needs quickly and effectively will always be an important role for NGOs. Though such services may not be sustainable, their provision can offer a route to the better understanding of longer term needs".

3. *Role of the funding agencies*

As the International Funding Agencies, including CARITAS and CIDSE, receive more funds from their Governments and therefore become more dependent on official Government Aid programmes, is there not a worry that they will experience a loss of independence in relation to their original funding charism and policies? Will they loose their flexibility, their innovativeness? Are we already beginning to see the tangible convergence of NGO's and official aid agencies? Has the word "sustainability" now become synonymous with aid grants due to such pressure?

In 1993 Oxfam received 24% of their budget from the British Government's ODA Programme; SCF received 37% and Accord 31%. In countries where the Catholic population and so the funding base is small, most of the CARITAS funds come from Government. While in no way criticising these CARITAS agencies, our experience is that they must dance almost 100% to the tune of these powerful donors.

Sustainability is acknowledged as a donor-inspired necessity but perhaps cannot be applied in the real world of the recipient who is faced by all the underlying problems present in the developing world. This is nowhere more true than in the area of health care. Many NGO's seek to solve their sustainability dilemma by looking for another funding agency at the end of the project funding period when the money runs out. However, with the convergence of many of the Catholic Funding Agencies in sharing information on the programmes which they fund, will this strategy continue to be possible? Are we seeing the beginning of the new Multinationals who will control who gets what and how often?

4. *Debt compounded by AIDS*

80% Of Uganda's export earnings go to servicing the foreign debt. The debt crisis is draining the country of financial resources and is undermining the prospects for sustainable economic growth. In 1992 Uganda spent approximately five times more on debt servicing than on the health of its citizens. As the Ministry of Health stated recently in their three year plan: "Debt has reduced government's ability to provide resources to the health sector".

5. *Financial impact of HIV/AIDS on health care delivery*

The Panos Dossier book on "The Hidden Cost of AIDS" states that "Money should be directed towards HIV/AIDS care and treatment. Care is part of prevention. Failure to treat in not only unethical but it adds to the stigma of the diseases and encourages its spread.".

AIDS can tear apart the fabric of society, since it primarily hits those of reproductive age, usually the breadwinners. With little or no state welfare in developing countries, the immediate or extended family has to cope if members fall ill. The longer a person is ill, the greater the economic impact on the household of the loss of their labour. Compare this to Ireland, one of the poorer countries in the European Union, where in 1995 the Social Welfare system accounts for one-third of Government spending, over £4,200 million. About one-and-a-half million people out of a population of three-and-a-half million receive Social Welfare income support payments.

6. *Kitovu Hospital experience*

a. Background statistics

Kitovu Hospital, run by the Medical Missionaries of Mary, is situated in the south west of Uganda, near Lake Victoria, 120 Kms. from Kampala, on the trans-African highway to Tanzania, Rwanda and Zaire. It serves the Districts of Masaka, Rakai and Kalangala which have a population of 1.2 million people, plus some patients who come from neighbouring districts. The Hospital has 230 beds and various out-patients clinics.

This is where AIDS was first seen in the early 1980's. No one knows how many people have died from AIDS in this area, but it is probably in the region of several thousand people. There is not a single family who has not had several members already die from AIDS and others currently ill or HIV positive. The adult HIV prevalence rate in these Districts is estimated to be at the level of 15% but in many of the trading centres and towns the incidence is 52% of the adult population. There are over 150,000 AIDS' affected orphans to prove this, whose parents have died from AIDS. In Rakai District 75% of all children under 15 years of age have lost one or both parents due to AIDS. Between 40-50% of babies born to HIV positive mothers are also infected.

AIDS accounts for half of all mortality in the total population in the area. In young adults under 35 years, those who are raising families, working the fields, running the schools,clinics and hospitals, 9 out of 10 deaths are HIV related. Or to put it another way, only one death in ten is not HIV-related.

b. History

It is probably no idle boast to say that since the beginning of the AIDS pandemic, Kitovu Hospital and it's outreach programmes has received one of the highest rates of visitors in the world. As Medical Missionaries of Mary, hospitality is part of our charism but even St. Benedict, from whom we take this attribute, would have had problems at times! However, despite the hundreds of visitors from funding agencies, governments etc. funds were mostly only forthcoming for the out-reach programmes concerning Home Care; Preventative AIDS Education; Counselling and Training Programmes.

Most of these people visited the hospital and it was explained to them the tremendous strain that AIDS was putting on the hospital resources in terms of personnel and finance. All nodded sympathically, but explained that their policy does not permit them to give funds or supplies to the hospital. Home Care was then (but will it remain so?) most attractive, yet how many funded Home Care Programmes are being run without hospital backing? And although Home Care is ideal for many patients, what happens if they need more specialised treatments?

The Home Care Programme operating out of Kitovu Hospital cared for over 3,000 individual patients in 1994, but this was in a particular area. What happens to AIDS patients who must come to the hospital because they are in areas not served by the Home Care Teams? If they have insufficient money, who pays their bills?

c. Case studies

Number 1

Rose is 2 years old and was admitted to the children's ward with cerebral malaria and severe anaemia. On admission she was given intravenous quinine for 24 hours. Later she had to be given blood due to her severe anaemia. She was also treated for pneumonia.

Her mother cared for her but was obviously suffering from AIDS herself. Rose was tested and found to be HIV positive. The mother said that every few weeks Rose has some illness and she has to take her to the local clinic for treatment for malaria, diarrhoea, sores, skin rashes etc. She must pay for the drugs before she receives them. When she herself is ill she does not go for treatment as she cannot afford it. But she cannot look at her child being ill and untreated.

Her husband died last year and she has three other children at home under the age of 10 years. She has no land and digs for others to get money for food. Her husband was a policeman and not from this area but she sees no point in going back to her village as she has no close relatives left there. They have died from AIDS. She cannot afford to send her children to school.

Rose was in hospital for 7 days and her bill came to $20. This included hospital food for her mother as she had no time to prepare her own food or money to buy anything in the local shops. The mother had spent $3 on transport to the hospital and needed the same to return home. She had only $4 which she had borrowed from a neighbour. She asked for work in the hospital to pay her bill but with the knowledge of her three small children at home plus herself not being well, was this a request to be granted? But if we are to be sustainable in Kitovu Hospital what is the solution to this real event?

Number 2

Namata is a widow and a grandmother with 18 children to care for. The oldest is 15 years of age and the youngest is 1 year old. She has lost 5 of her sons from AIDS. Four of their wives also died and the other one "ran mad" and she has not seen her since. According to the culture, the children are the responsibility of the paternal side so, as their fathers died, their children came to her. During these past two years, she has also nursed two of her daughters, until they also died from AIDS.

Namata has two acres of land which she cultivates with her children. However, when her daughters were ill, she had to spend much time caring for them. She also spent time visiting her sick sons and there are always sick people to visit in the villages and burials to attend and so valuable cultivating time was lost and now part of her land is in bush.

While trying to save her one year old grandchild from pulling the large matooke cooking pot, full of boiling water, on top of her, Namata sustained bad burns to both her legs. For the first week she lay at home using local herbal treatments, refusing to leave her children. She was also painfully aware that she could not afford to have hospital treatment. Eventually, when infection had set in and the excruciating pain she could bear no longer, her neighbours brought her by bicycle and taxi to Kitovu Hospital, a journey which took most of a day. She has been in Kitovu for four weeks now, having daily dressings to both legs. She also needed skin-grafting and anti-biotics plus analgesics in plenty and is on hospital food. The children are living on their own and a neighbour is caring for the one year old.

Her bill to date is $150 and she is not ready for discharge yet but is anxious to go home. Where is she to get the money to pay her bill? What is the hospital to do to be sustainable?

Number 3

Paul is 32 years and a teacher. He was a passenger in a taxi which had an accident and received multiple fractures, lacerations, chest and abdominal injuries including a ruptured spleen. On admission, he needed extensive surgery, was on large doses of anti-biotics, analgesics and Intra-venous therapy. He is married with six children and also cares for four orphans. He has been ten weeks in hospital due poor healing ability, his wounds keep breaking down. (He is HIV positive.) His bill so far is over $300. The taxi had no insurance so he will receive no compensation. As a teacher he earns $40 per month, but Government has not paid salaries for four months now, which is the usual occurance for Government employees. He says he wants to pay his bill but has no idea how he will do this as his immediate and extended family are peasant farmers and poor. What will the hospital do when he is discharged? Who will compensate them?

One could fill pages of similar case studies all emitting from Kitovu Hospital and other hospitals caught in the middle of this tension of how and indeed whether to treat patients who are unable to pay 100% of their bills.

d. Financial cost

As stated, 43% of the Health Services in Uganda are provided by mostly Catholic and Protestant Mission NGO's, yet they receive no financial assistance from Government, not even staff salaries.

Staff at Kitovu have calculated that all patients would like to pay their bills but only 30% can pay 100%; 45% pay a portion and 25% are unable to pay anything.

Many of the patients presenting in Kitovu Hospital have AIDS' related illness. Before AIDS, these illness' were successfully treated in a fraction of the time it now takes. Maternity cases were generally straight-forward in regard to healing and discharge time, now it is more common for post-delivery and gynaecology patients to spend much longer in hospital due to infection. Many patients attend hospital when their illness is at an advanced stage. Interviews conducted in the area suggest that poverty and lack of access to cash, limits the extent to which people can afford to purchase drugs or go to hospital.

Nysambya Hospital in Kampala estimates that 70% of total bed occupancy is due to AIDS related conditions. These figures would also be true for the other hospitals in Kampala. In Kitovu Hospital the estimates are similar.

The Lancet of February 1994 writing about Health Care in Uganda, where in 1991 the Government spent $1.3 per person, (this had decreased to $1.1 in 1994) mentioned the effects of low health expenditure over an extended period of time. First, maintenance of buildings is postponed, indefinitely. Second, equipment and vehicles are not repaired or replaced.

Finally, bills and salaries are paid late and drugs are under-supplied. As money becomes more scarce, personnel costs begin to consume a major portion of the recurrent budget. Thus the consequences of recurrent budget strain include a large number of poorly motivated health workers who cannot deliver care for lack of essential supplies - and the health system collapses.

In the Kitovu Complex Evaluation Report of 1994 which was supported by CAFOD, the recommendation regarding financing reads: "Funding agencies should recognise that their support for HIV/AIDS projects in Kitovu does rely a great deal on the existence of the hospital.

They should develop a funding formula which provides an additional factor for hospital provision as a necessary element in all HIV/AIDS projects, i.e. they support a more holistic approach to patient care. Funding agencies should re-examine the amount allowed in project funding for administration and accounting, to ensure it is sufficient to support the main task of the project".

7. What is the future forr Kitovu Hospital?

This is an extremely difficult question to answer, but it is probably also being asked by many other mission hospitals and I hope by some of the donor agencies here to-day!

Presently we are looking at a number of options in relation to sustainability for the hospital. Private out-patient clinics and a private wing. One of the difficulties about this is that it would provide services for people who could afford to avail of the private clinics already existing in Masaka. Also if it were to generate sufficient income to help subsidise the rest of the hospital it would have to be a large unit and present indications are that the percentage of the population of Masaka who can afford to avail of it, is inadequate to make it viable. This would entail capital expenditure plus recurrent costs as more staff would have to be employed. Income-generating projects...an area in itself which captures the imagination of the donor agencies, but like sustainability is full of problems and would require capital plus extra staff and management. Hand-over categories of patients to the local government hospital. This has been done in the case of orthopaedic and T.B. patients. However, unless the patients have money to pay in bribes, they are not treated and many have arrived back to Kitovu in an even worse state. Hand over the hospital. This seems like the way we will have to go. The hospital belongs to the Bishop/Diocese. We have had meetings with him and his team explaining that as we are unable to find funding, that we will be unable to run it in the near future.

And what will the consequences be if we do hand-over? If we are unable to get funds, it is doubtful that a local congregation or group will be. The hospital will become 100% fee paying. What will happen to those who are unable to pay all or part of their bills?

They will simply go without medical care, become ill and un-self-reliant, die before they need to and more rapidly expand the number of orphans needing care in the Diocese.

8. Conclusion

Perhaps the one question that should guide sustainability guidelines is: will this help in the long-run to increase the recipients' self-reliance? or Will it raise the capacity of individuals to improve their lives in some permanent way? When people are ill they are unable to be self-reliant, they are a financial burden on society. Could a hospital or out-reach programme not interpret sustainability as meaning that these people who have directly received health care from it are able to resume their activities and so contribute to the economic and social life of their community and nation?

The future, regarding the provision of Health Care Services, is going to be busy! We are going to see an even greater increase of HIV/AIDS related illness as those who are currently HIV positive become ill and ask for care. As many of the carers and hospital personnel are and will be also ill, we will see more de-motivation, stress and burn-out among them.

The last question is left to the donor agencies! Are the Catholic funding agencies prepared to put some of their money where they say their Christian priorities are....prepared to make a concrete commitment to the development of the whole person, which in this current AIDS pandemic includes healing, in order to realise sustainability.

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Annex

UGANDA BASIC DATA.

Area (sq.km) :	197,000 sq. Km.
Population :	7,500,000 (1991Nat.Pop.Census)
World listing :	4th. poorest country
Main export :	coffee = 60% of export earnings
Infant mortality :	118 per 1,000 live births.
Life expectancy for males :	41.8 years
Life expectancy for females :	45 years
(In 1988 life expectancy was 53 years)	
Population per physician :	1 : 22,000
Rate of inflation 1993 :	5% (1986 = 260%)
1994 - foreign debt :	$2.6bn. (92% of GNP)
1994 - Servicing of debt :	$100 million
1994 - Health budget :	$ 20 million or $1.1 per person.
(this is Government expenditure)	
Percent of total government spending allocated to health :	4%
Provision of health services :	43% by NGO's, mostly Church-related.

(sources: Uganda Government, World Bank and UNICEF)

Experience with an Alternative Health Care System in Phu Luong District, Vietnam

Dr. Nguyen The Thach

I am a Vietnamese physician and spent my childhood, as many adult Vietnamese did, in countryside where I went to the local schools and used my free-time to work in the field. Returned to the peaceful countryside after my years of studying Medicine at the Ha noi Medical School, I was offered a position in a small district hospital. This was in 1967. Visiting with the farmers at their homes and talking with them friendly was part of my work and I enjoyed it very much. In 1970, I was appointed to a Highland provincial hospital to provide health care to rninority ethnic groups. I returned to my home district in 1977 and was appointed the director of the district hospital.

At that time, even in the district hospital, there were deaths from eclampsia, neonatal tetanus, ARI and late diagnosed appendicitist that were a result of ignorance and carelessness on both sides, the people and the health workers. Because of this, I developed an interest in preventive health care with an emphasis on health education on very simple topics. Along with some of my colleagues, I believed that the solution to many of the emerging health care problems was to have people understand how to be healthy and practice good health habits

While I was engaged in working with the idea of community involvement in health care, I was again assigned to a new job. I became the Coordinator of National Population, Family Planning and Primary Health Care. After working in Ministry of Health for a couple of years, I knew my ideas of integrated health care projects and community involvement did not have a lot of support. Around 80% of our population is engaged in farm work. Working with the community means working in remote rural areas without electricity, with poor accommodations and with difficult access. Many people in high, responsible positions and many health workers, only gave speeches supporting the ideas of community involvement. They did not do anything. So I had to leave the Ministry of Health in 1991 and joined CIDSE.

Prior to 1991, CIDSE's health activities were not focused. The activities were mainly technical assistance and equipment: providing an ambulance and medical instruments; building a hospital water system. In 1991, the Primary Health Care project of Phu luong district was submitted and approved for three years. The aims of the program are to:

- Increase access of the population to PHC services
- Improve the quality of PHC services.

Difficulties encountered in Implementation of PHC project

- Phu luong is a mountainous district composed of many hard to reach communes. The roads are more suitable for travelling by foot, horse or boat than by car.
- The population of mixed ethnic groups is scattered and has a low education level.
- The former social welfare projects no longer exist because of the newly introduced free-market economic.
- "Support" or "aid" used to mean to people that a large amount of goods, money and equipment was going to be given to them with no repayment necessary.
- Health care was viewed as the responsibility of the health system only.
- People had lost their trust in the local health services because of the deterioration of the system coupled with arrogant behaviours and poor performances of the health workers.
- Many communes did not even have health station anymore.
- People saw the previous CIDSE projects as some thing from the outside, not belonging to them.

In 1991, the health of the population was in danger of many preventable diseases. Malaria, polio, diphtheria, neonatal tetanus, whooping cough, measles...were rampant. There were national vertical health projects but they did not accomplish much. Projects like the EPI (Extended Immunisation Program) were costly. The main problems lay in the lack of awareness and participation by the people and in the lack of knowledge by the Health Workers in how to involve community and encourage their participation.

Project orientation and community approach

The project goals were clear but how to achieve them ? By what means ? It really was a great challenge to me as the project officer. I spent one whole year getting to know what people did at different levels, thinking about the concept of PHC, thinking about CIDSE and how the two would cooperate.

In early 1992, the way became clear: Community-Based Primary Health Care, an approach where health care is provided to people based on the health needs of the people themselves. Guided by that principle, all of project activities were brought to local people for discussion. The people figured out their own goals, their own action plans, their own time schedules and determined who would do what. They also became the evaluators of their activities.

How did we get all the people involved?

- Establishment of the District Trainers Group: Health Trainers was the first priority.
- Creation and Training of the Village Health Volunteers.
- Set-up and Training of the Volunteer Village Development Committees.

Current situation of PHC project in Phu luong district *The trainers group* This group is composed of 25 physicians working at the District Health Centre and Commune Health Stations. They received training on teaching skills, planning, monitoring and supervising PHC activities. Their acquired knowledge of PHC is being taught to other health workers, village health volunteers, and villagers. Now, in order to meet the needs of development in the district, the trainer group is being expanded to include more members. The new members are non-medical professionals from other sectors like agriculture, education, Women's' Union. The idea of a multisectoral approach in integrated PHC could only happen when the other parts of the district became actively involved.

Village Health Volunteer

Every village in the district has village health volunteers. The total number of volunteers is close to 600. These volunteers, selected by villagers, are their closest point of the health system. They are the health educators for the village]age and will be the first-aid providers. They bridge the distance between health professionals and the population. Through them, two ways communication is achieved.

Volunteer Village Development Committee

The members of these committees are selected by villagers from different sectors of the village. They are given the tasks of development of the village. They work with villagers, collect all opinions and suggestions, make decisions and are responsible for the action plan. They are carrying out the Integrated Community-Based Primary Health Care and Development model. This model of village development is proving to be successful and will continue to get attention from CIDSE in the future.

Lessons learned

Having been involved with the PHC project in Phu luong district for years, I have seen the positive outcomes and drawn the following conclusions:

- Health care activities must be based on the health care needs of the people.
- Health workers at all levels should know how to work with the community and encourage peoples' involvement.
- Health workers should be professionally competent and also, more important, have the social skills that enable them to work with local people.
- Health workers should have respectful social skills for working with minority ethnic groups.
- It is crucial to create a group of people who are capable and compassionate.
- The project officers and health workers must participate in the whole process. Standing with the local people, gives them the more "true" feelings and more "proper" actions.

Conclusions and recommendations

Summary of group reflections

Analysis of problems

Church

- A theology of Church mission has not been adequately articulated and this has a negative impact on the delineation of appropriate goals and objectives and on quality of Church-based health care;
- there is a tendency to concentrate on micro-ethical rather than on macro-ethical issues;
- a lack of sufficient openness to community participation and to concentration of efforts with government and non-governmental organisations in the same field often leads to an isolated, "paternalistic", "top-down", institutionally-based and financially and socially non-viable approach;
- there is inadequate professional training for leaders and workers in church-based health care, especially in the area of professional and financial management;
- there is frequent staff turnover among religious; incapacity of some religious congregations to assure continuity in staff expertise.

Government

- There is a lack of stated vision, mission, analysis, goals and objectives and of political will to promote a health strategy which is based on equity and which favours a community-based approach;
- inverted funding policies allocate the vast majority of resources to tertiary care which serves the least numbers of people;
- there are pressures from international financial institutions and from other national priorities (e.g., military);
- there is resistance to allowing local communities to determine their own priorities and to assume responsibility for managing health services in their respective areas - this leads to vertical programmes and dependency mentality;
- health professionals are poorly prepared, especially in community-based philosophy and techniques;

- insufficient financial resources and inappropriate allocation and use of technology cause additional burdens;
- corruption and dishonesty are present;
- there is a lack of commitment to an inter-sectoral and interdisciplinary approach to health which addresses the non-biological causes of poor health - e.g., injustice, lack of potable water, civil conflict, rural-to-urban flight, lack of employment opportunities, gender inequity, lack of opportunities for education and integrated human development.

Non-governmental organisations

- Staff and volunteers are not sufficiently trained, especially in the area of community-based health care;
- there is a proliferation of NGOs without clear mission, goals and objectives; competition for scarce resources; risk of falling into a dependency mode; corruption among some NGOs;
- these organisations tend to be self-perpetuating, at times blocked in traditional approaches which are no longer responsive to present needs, especially on the local level;
- these organisations too often are organised and operate with a "top-down" approach; this can cause inefficient use of resources and irrational assignment of staff responsibilities.

Local communities

- They lack empowering education and preparation to plan and manage community-based health care;
- there are difficulties with conscientizing, changing mentality and engaging local population in this approach;
- poverty hinders access to health care;
- the lack of accessible community-based health care forces people to inappropriately use more sophisticated levels of health services;
- they suffer from a lack of self-confidence and thus do not have a feeling of ownership;
- there is a lack of harmonisation between traditional and "scientific" medical approaches;
- they struggle with a series of social problems which lead to poor health conditions, e.g., poor and inadequate housing, poor sanitation, lack of basic education isolation and discrimination toward certain ethnic groups, problems in communication health professionals may not be familiar with local languages and culture).

Donor agencies

- They often adopt an emotionally-based or partial response to problems without filling consulting and planning together with affected the communities and populations;
- differing political, financial, and ideological policies cause confusion in the field;
- they often follow a bureaucratic, centralised, and overly rigid approach;
- they tend to shift funding policies without prior planning with those receiving funds and without adequate explanation for such decisions;
- they do not always perform critical analysis of the local situation, context, and culture before making decisions about funding;
- they tend to prefer vertical programmes because these are easier to monitor but are not always well adapted and attentive to the local situation.

International structures - macro-economic influence on health care

- Structural Adjustment Programmes, imposed as a result of the debt crisis, often dictate a decrease in government health care allotments in the national budget;
- multi-national pharmaceutical industries exploit countries with less financial resources and discourage the use of generic medications;
- countries with greater financial resources make funding decisions on international aid and development based on foreign policy considerations and do not sufficiently support health and social services.

Roles and responsibilities

Church

(with a theological, sociological, and legal character including all persons (lay persons, religious, clergy) who believe in Jesus, follow his teachings, celebrate his sacraments, and continue his mission of establishing the Reign of God by word and witness - has some characteristics of non-governmental organisations, especially in its human development and health-related services, but also accounts to the higher power of God)

- Insure the continuation of Jesus' healing mission through solidarity with all of humanity, but especially with the most disadvantaged;
- promote sustainable health care for all by:
  - advocating from a value-based perspective with governments and society-at-large,
  - re-defining and re-orienting its own service institutions,
  - offering integrated, holistic health-related education and services in partnership with governments and non-governmental organisations with a similar mission,
  - adequately training staff and volunteers engaged in church-based health care efforts,
  - providing for appropriate and accountable management of its services,
  - encouraging a community-based reflection on micro and macro-ethical issues,
  - promoting and collaborating with community-based planning and management of health care,
  - assisting the voiceless to express their needs and to be empowered in the active solution of their problems.

Government

- Recognise and respect the basic human right of health care for all;
- design policies and set norms which will guarantee this basic human right;
- mobilise adequate resources and make appropriate allocations in insure community-based health care for all on an equitable basis;
- promote collaboration among various governmental, church-related, and non-governmental organisations involved in health care education and delivery of services and monitor the quality of such services;

- ensure the supply of basic medications, health supplies and equipment, and well-motivated and adequately-paid health care workers at all levels of health service delivery system, but especially at the level of local communities;
- promote dialogue and collaboration with traditional health practitioners and promote better understanding of traditional medicine, especially on the level of local communities;
- collect data related to trends in health;
- provide for international representation and advocacy on behalf of the health and social needs of its citizens.

Non-governmental organisastions

- Advocate, especially in the area of policy development and in the articulation of new models of health care;
- empower and educate local communities to prepare them to assume responsibility for their own health needs all for management of locally-based services;
- sponsor and deliver health-related education and services which are complementary to, but not duplicative of, similar efforts by the government, non-governmental organisations, and local communities.

Local community

- Study, articulate, and formulate plans based on the needs and preferences of the local population (includes the collection of basic statistics on health and social conditions);
- mobilise local resources and external assistance (when needed and appropriate);
- devise innovative partnerships in order to assure adequate health care for all local citizens;
- respect free choice, culture, capacity and will of local citizens;
- organise and maintain responsibility for locally-based health education and services;
- monitor and evaluate the results of health actions on the local level;
- follow basic planning methodologies:
  - articulation of hopes, dreams and vision as a community,
  - identification of needs / problem analysis,

- prioritization of needs,
- identification of solutions,
- planning, implementing, evaluating.

Donor agencies

- To advocate on behalf of partner and member organisations which deliver health-related education and services and on behalf of they communities which they serve;
- make themselves available to humbly and honestly listen to and respond to the needs of local communities;
- participate in the development of community-based health care;
- share resources (financial, technical, and human) with those most in need;
- avoid imposition of ideological or philosophical approaches which do not conform to local needs and realities;
- network with other donor agencies, governments and institutions in order to avoid duplication or conflict in collaboration with local partners.

Characteristics of sustainable health care

Basic agreement with traditionally-accepted principles of the 5 "A's; other characteristics to which attention should be called:

- social acceptability (community owned and managed);
- political stability (rooted in representative community body);
- economic viability (optimal use of local resources);
- respect for ecology;
- cultural appropriateness;
- oriented toward liberation rather than dependency;
- based on the principles of interdependency and solidarity;
- equity, empowerment, efficiency, effectiveness.

Recommendations for future lines of action

1. The Church leaders need to promote a co-ordinated approach to health care which includes:
   - improved co-ordination structures with the capacity to represent the needs of church-based health services, facilitate their mutual collaboration and enable the co-ordinated procurement of medications, equipment, and supplies;
   - promotion of inter-sectoral collaboration among medical, pastoral, and social development offices, agencies, institutions, and workers;
   - openness to co-operation with government, non-governmental organisations with similar missions and activities;
   - formation of laity, religious, and clergy who are involved in provision of health care and other pastoral and social services;

2. National and international church-related structures need to undertake advocacy efforts to address the root causes of poor health which are found in inadequate social development and to eliminate unjust and inequitable policies which lead to the further impoverishment of those who already the most vulnerable.

3. All those who are involved in providing for health care (governments, international structures, churches, non-governmental organisations, donor agencies, and local communities) need to encourage and facilitate people's participation and involvement in:
   - assessment of local health situations
   - identification and prioritization of problems
   - identification of local resources
   - building community-based organisational structures.

4. Governments need to launch a process of transformation of health services which is attentive to:
   - locally-defined needs and plans
   - appropriate technology
   - traditional medicine
   - cost-effectiveness

5. All those involved in the provision of health care need to plan high quality services which:
   - are based on good management principles;
   - are acceptable to the local populations whom they serve;
   - are holistic;
   - employ a friendly and caring approach;
   - make available essential medications;
   - offer health care financing options and have affordable user fees;
   - employ competent and qualified personnel;
   - utilise referrals to appropriate services which are based on a intra- and inter-sectoral partnerships;
   - are gender sensitive.

6. Donor organisations need to explore possibilities of providing long-term financial commitments which are open to funding recurrent costs.

7. Those receiving funds need to create an enabling environment for community participation in the identification, implementation, and evaluation of locally-based community health care and to promote greater co-ordination and collaboration among the various sponsors of health care on local and national levels.

8. The sponsors and participants in this Workshop need to ensure
   - that a report of the plenary presentations, group reflections, and recommendations be prepared by a small team, published and disseminated widely;
   - that a process of further reflection and sharing of experiences, information and insights related to sustainability of health care be continued on local, national, regional, and global levels be initiated and implemented.

Fr. Robert Vitillo

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